THE INTERNATIONAL SOCIETY FOR
TRAUMATIC *stress* STUDIES
ISTSS

24th ISTSS Annual Meeting

Terror and its Aftermath

November 13 – 15, 2008

Pre-Meeting Institutes November 12

The Palmer House Hilton • Chicago, Illinois USA

Final Program and Proceedings

Jointly Sponsored by Boston University School of Medicine and the International Society for Traumatic Stress Studies

www.istss.org

The largest gathering of professionals dedicated to trauma treatment, education, research and prevention

The 24th ISTSS Annual Meeting is supported in part by educational grants from the following:

Platinum Supporters

Lilly

Eli Lilly and Company

This event is also supported by

NIMH National Institute of Mental Health
Reducing the burden of mental illness and behavioral disorders through research on mind, brain, and behavior

National Institute of Health Grant Number R13MH078814 from the National Institute of Mental Health.
The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institute of Mental Health or the National Institutes of Health.

Bronze Supporter

healthjourneys
Resources for Mind, Body and Spirit

Patron Supporters

Gift from Within
www.giftfromwithin.org
A-V Resources on PTSD

The Trauma Disorders Program at Sheppard Pratt
Treatment for all stages of trauma recovery

Save the Date

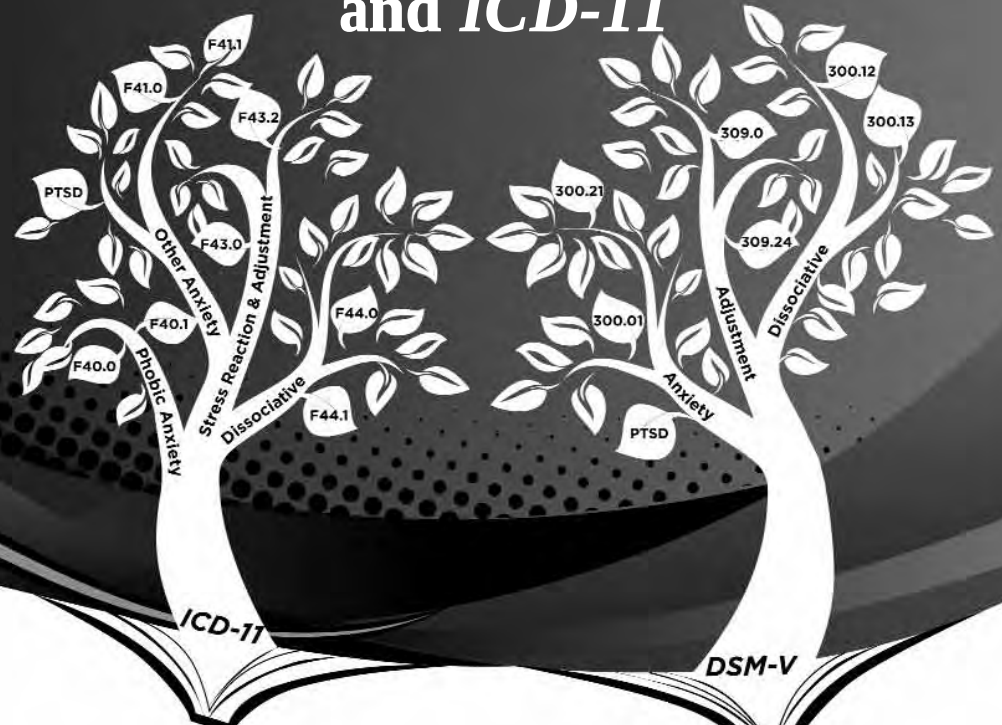
THE INTERNATIONAL SOCIETY FOR TRAUMATIC stress STUDIES
ISTSS

ISTSS 25th Annual Meeting

November 5 – 7, 2009
Pre-Meeting Institutes November 4

The Westin Peachtree Plaza
Atlanta, Georgia USA

Traumatic Stress Disorders: Toward *DSM-V* and *ICD-11*



Silver Anniversary Meeting

www.istss.org

Table of Contents

111 Deer Lake Road
Suite 100
Deerfield, IL 60015 USA
Phone: +1-847-480-9028 Fax: +1-847-480-9282
E-mail: istss@istss.org
www.istss.org

Dear Colleagues,

Welcome to the 24th Annual Meeting of the International Society for Traumatic Stress Studies. As usual, the program features high quality, multi-disciplinary presentations from a broad range of perspectives, countries and cultures, with 'state of the art' scientific and clinical perspectives on traumatic stress.

This year's theme is "Terror and its Aftermath" and many of the presentations reflect this, including sessions on the effects of terror on the military, on refugees and on children (including adult survivors). Our keynote speaker, Professor Cherif Bassiouni, will set the scene, highlighting the importance of a legal and human rights framework for the understanding, prevention and relief of traumatic stress.

Exclusively this year, we have a full day of scientific presentations relevant to the development of the fifth edition of the *Diagnostic and Statistical Manual (DSM-V).* We are delighted to welcome Dr. Katherine Phillips, chair of the APA Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic and Dissociative Disorders Workgroup to introduce this event and hear our discussions, as well as no fewer than seven ISTSS Presidents amongst the list of eminent invited speakers. We believe this area is fundamentally important not only to those involved in research and diagnosis but to all whose program funding and advocacy work depend on having a robust framework in the *DSM.*

This is in addition to the usual range of scientific and clinical sessions covering the whole field of traumatic stress. There are invited presentations on the biology of PTSD, trauma and reparative justice and an important session presented by journalists on the problems faced by soldiers at war. This year, we also have a record total of six master clinician sessions, covering such diverse topics as children, cognitive therapy, refugees, EMDR, complex trauma and early responding.

As always, there are numerous panels, workshops and symposia from which to choose. We have continued this year with the single paper presentation format – the deputies and co-chairs have assembled numerous sessions based on paper presentations. We hope this relatively new format will continue to enrich the conference experience for both presenters and attendees. We are also continuing the same structure for poster presentations from previous years. Posters are on display throughout the conference days for people to view, and authors will be available to discuss their posters at the end of each day of the conference. At the last poster session there will be a small closing reception, to reward those with stamina!

There is a full social program. We have arranged a dedicated ISTSS venue with a cash bar to facilitate meetings with other attendees on the Wednesday evening, before the main conference starts. There is the usual welcome reception on Thursday evening, following the ISTSS business meeting and awards ceremony and later, in an adjacent room, the opportunity for dancing. On Friday evening, there will be a reading of a play based on Jonathan Shay's *Achilles in Vietnam.*

Our goal is to foster communication between basic scientists, clinicians and policy makers in order to advance the integration of current scholarship and practice. By doing this we hope to advance understanding that will promote the dismantling of the conditions that produce trauma, as well as facilitate the mitigation of adverse responses to traumatic experiences.

We have enjoyed putting together this program and are looking forward both to the presentations and posters and to meeting all of you in person.

Jane Herlihy, DClinPsych
24th Annual Meeting Chair

Stuart Turner, MD, MA, FRCP, FRCPsych
ISTSS President

Program Committee

Program Chair
Jane Herlihy, DClinPsych

President
Stuart Turner, MD, MA, FRCP, FRCPsych

Program Consultants
Yael Danieli
Matthew Friedman
Terry Keane
Dean Kilpatrick
Paula Schnurr

Deputies
Yael Caspi
Douglas Delahanty
Deniz Fikretoglu
Rochelle Hanson
Elizabeth Hembree
Karestan Koenen
Candice Monson
Yuval Neria
Barbara Niles
Meaghan O'Donnell
Miranda Olff
Nnamdi Pole
Bruce Shapiro
Roger Solomon
Murray Stein
Andrew Stone
Elisa Triffleman
Amy Wagner
Jennifer Wild

Student Program Co-Chairs
Lynette Averill
Joanna Legerski

Reviewers
Carolyn Allard
Maureen Allwood
Amanda Amstadter
Charles Benight
Iva Bicanic
Sandra Bloom
Cameo Borntrager
Michelle Bosquet
Laura Campbell-Sills
Yael Caspi
Kathleen Chard
Mylea Charvat
Carla Danielson
Douglas Delahanty
Laura DiGrande
Susan Doron-LaMarca
Shannon Dorsey
Mark Dworkin
Iris Engelhard
Kim Felmingham
Deniz Fikretoglu
Lisa Fisher
Monica Fitzgerald
David Forbes
Julia Frank
Marc Gameroff
Bita Ghafoori
Karni Ginzburg
Steve Gold
Carolyn Greene
Anouk Grubaugh
Stephanie Guay
Robin Gurwitch
Rochelle Hanson
Ellen Harrington
Alesia Hawkins
Elizabeth Hembree
Amy Herschell
Devon Hinton
Lisa Hooper
Kelly Hughes-Bernardi
Matthew Jakupcak
Marianne Kabour
Anke Karl
Debra Kaysen
Anthony King
Christine Knaevelsrud
Karestan Koenen
Karen Krinsley
Ariel Lang
Patti Levin
Shira Maguen
Michael McCart
Shallon McCaslin
Anne Milde
Mark Miller
Candice Monson
Julia Mueller
Briana Nelson Goff
Yuval Neria
Barbara Niles
Terry North
Nicole Nugent
Meaghan O'Donnell
Miranda Olff
Oxana Palesh
Ruth Parslow
Suzanne Pineles
Nnamdi Pole
Stephen Quinn
Sheila Rauch
Don Richardson
Andrea Roberts
Genelle Sawyer
Jeremiah Schumm
Shannon Self-Brown
Bruce Shapiro
Elan Shapiro
Norman Shields
Lisa Shin
Jillian Shipherd
Marit Sijbrandij
Alan Simmons
Eve Sledjeski
Roger Solomon
Murray Stein
Brad Stolbach
Andrew Stone
Eun-Jung Suh
Sarah Suniga
Elisa Triffleman
Elena Tuerk
Amy Wagner
Jennifer Waltz
Mariann Weierich
Jennifer Wild
Anke Witteveen
Erika Wolf
Bronwyn Wolfgang

ISTSS Executive Committee
President
Stuart Turner, MD, MA, FRCP, FRCPsych
Vice President
Ulrich Schnyder, MD
Secretary
Marylene Cloitre, PhD
Treasurer
John Fairbank, PhD
President-Elect
Patricia Resick, PhD
Past President
Elana Newman, PhD

ISTSS Board Members
Jean Beckham, PhD
Richard Bryant, PhD
Mark Creamer, PhD
Norah Feeny, PhD
Joop de Jong, MD, PhD
Sandro Galea, MD, DrPH
Stevan Hobfoll, PhD
Danny Kaloupek, PhD
Nancy Kassam-Adams, PhD
Andreas Maercker, MD, PhD
Alexander McFarlane, MD
Josef Ruzek, PhD
Bessel van der Kolk, MD
Rachel Yehuda, PhD
Lori Zoellner, PhD

ISTSS Headquarters Staff
Executive Director
Rick Koepke, MSW
Administrative Director
Diane Rutherford
Administrator
Marti Buckely
Conference Director
Jacky Schweinzger
Conference Administrator
Shalini D'Souza
Manager of Marketing and Communications
Deanna Marchetti, MA
Director of Communications
Jill Hronek
Accountant
Liying Zheng
Education Manager
Kismet Saglam

Tuesday, November 11

4:00 p.m. – 6:00 p.m.	Registration

Wednesday, November 12

7:30 a.m. – 8:30 a.m.	Coffee and Tea
7:30 a.m. – 5:00 p.m.	Registration
8:30 a.m. – Noon	Pre-Meeting Institutes
10:30 a.m. – 5:30 p.m.	Bookstore
1:30 p.m. – 5:00 p.m.	Pre-Meeting Institutes
7:00 p.m. – 8:00 p.m.	First-Time Attendees/New Members Gathering
8:00 p.m. – 10:00 p.m.	Cash Bar Meet and Greet

Thursday, November 13

7:00 a.m. – 8:00 a.m.	Coffee and Tea
7:00 a.m. – 5:00 p.m.	Registration
7:00 a.m. – 6:00 p.m.	Bookstore/Exhibits
8:00 a.m. – 9:15 a.m.	Concurrent Session 1
9:30 a.m. – 10:45 a.m.	Keynote Address
9:30 a.m. – 6:00 p.m.	Poster Session 1
11:00 a.m. – 12:15 p.m.	Concurrent Session 2
12:30 p.m. – 1:45 p.m.	Student Luncheon Meeting
2:00 p.m. – 3:15 p.m.	Internship and Post-Doctoral Program Networking Fair
2:00 p.m. – 3:15 p.m.	Concurrent Session 3
3:30 p.m. – 4:45 p.m.	Concurrent Session 4
5:00 p.m. – 6:00 p.m.	Poster Session 1 With Authors Present
6:15 p.m. – 7:00 p.m.	Business Meeting
7:15 p.m. – 8:00 p.m.	Award Ceremony
8:00 p.m. – 11:00 p.m.	Welcome Reception
9:30 p.m. – 11:00 p.m.	Dancing

Friday, November 14

7:00 a.m. – 8:00 a.m.	Coffee and Tea
7:00 a.m. – 5:00 p.m.	Registration
7:00 a.m. – 6:00 p.m.	Bookstore/Exhibits
8:00 a.m. – 9:15 a.m.	Concurrent Session 5
9:30 a.m. – 10:45 a.m.	Concurrent Session 6
9:30 a.m. – 6:00 p.m.	Poster Session 2
11:00 a.m. – 12:15 p.m.	Concurrent Session 7
12:30 p.m. – 1:00 p.m.	Meet the ISTSS Diversity Committee
12:45 p.m. – 1:45 p.m.	Special Interest Group (SIG) Meetings (bring your own lunch)
2:00 p.m. – 3:15 p.m.	Concurrent Session 8 (includes Internship and Post-Doctoral Program Networking Fair)
3:30 p.m. – 4:45 p.m.	Concurrent Session 9
5:00 p.m. – 6:00 p.m.	Poster Session 2 With Authors Present/Book Signing
8:00 p.m. – 9:30 p.m.	Play Reading: *Achilles in Vietnam*

Saturday, November 15

7:00 a.m. – 8:00 a.m.	Coffee and Tea
7:00 a.m. – 2:00 p.m.	Bookstore/Exhibits
7:00 a.m. – 3:30 p.m.	Registration
8:00 a.m. – 9:15 a.m.	Concurrent Session 10
9:30 a.m. – 10:45 a.m.	Concurrent Session 11
9:30 a.m. – 6:00 p.m.	Poster Session 3
11:00 a.m. – 12:15 p.m.	Concurrent Session 12
12:45 p.m. – 1:45 p.m.	Special Interest Group (SIG) Meetings (bring your own lunch)
2:00 p.m. – 3:15 p.m.	Concurrent Session 13
3:30 p.m. – 4:45 p.m.	Concurrent Session 14
5:00 p.m. – 6:00 p.m.	Poster Session 3 With Authors Present/ Closing Reception
6:00 p.m.	Conference Adjourns
6:30 p.m. – 7:30 p.m.	Reception for VA and DoD Employees

About the International Society for Traumatic Stress Studies

ISTSS is an international multidisciplinary, professional membership organization that promotes advancement and exchange of knowledge about severe stress and trauma. This knowledge includes understanding the scope and consequences of traumatic exposure, preventing traumatic events and ameliorating their consequences, and advocating for the field of traumatic stress.

The society has a diverse membership from around the world. Members are social, behavioral and biological scientists; professionals from mental health and social services disciplines and individuals representing religious, legal and other professions. ISTSS activities include education, training and information resources.

THE INTERNATIONAL SOCIETY FOR TRAUMATIC stress STUDIES

Special Educational Opportunities

Plan to visit Chicago for five days of training and education in the field of traumatic stress. The **Fifth Annual Conference on Innovations in Trauma Research Methods (CITRM)** will be held November 16-17, 2008, at the Hotel Orrington (www.hotelorrington.com) on Chicago's North Shore, immediately following the Annual Meeting of the International Society for Traumatic Stress Studies. CITRM is devoted to research methods in the field of psychological trauma. For more information, visit www.citrm.org.

Registration

The ISTSS registration and CE/membership services desks are located in the Grand Ballroom Foyer/Registration Bay, 4th floor and will be open at the following times:

Tuesday, November 13	4:00 p.m. – 6:00 p.m.
Wednesday, November 14	7:30 a.m. – 5:00 p.m.
Thursday, November 15	7:00 a.m. – 5:00 p.m.
Friday, November 16	7:00 a.m. – 5:00 p.m.
Saturday, November 17	7:00 a.m. – 3:30 p.m.

Participation in the 24th ISTSS Annual Meeting is limited to registered delegates. Your full registration includes:

Education Sessions and Materials
- Admission to all program sessions (except Pre-Meeting Institutes, which require an additional fee)
- Admission to Poster Sessions
- Final Program and Proceedings

Networking/Social Events
- First-Time Attendees/New Members Gathering
- Awards Ceremony
- Welcome Reception
- Dancing
- Play reading
- Morning coffee and tea networking opportunities
- Special Interest Group (SIG) meetings
- Cash Bar Meet and Greet

Conference Features
- Keynote Address
- ISTSS Annual Business Meeting
- ISTSS committee and task force meetings
- Exhibits of products and services
- ISTSS Bookstore
- Multimedia CD-ROM of proceedings

Events Available for Additional Fee
- Pre-Meeting Institutes

Meeting Hotel and Meeting Rooms

All sessions and events at the 24th ISTSS Annual Meeting will take place at The Palmer House Hilton in Chicago, Illinois. A floor plan of the meeting facilities is included in your on-site registration material.

The Palmer House Hilton
17 East Monroe
Chicago, IL 60603 USA
Phone: +1-312-726-7500
Guest Fax: +1-312-917-1707
www.hilton.com

Attire

Attire for the conference is business casual.

Badges

The Annual Meeting badge you received in your on-site registration packet is required for admittance to all sessions and social activities. A fee may be charged to replace lost badges. First-time attendees are designated with sky blue ribbons. Please help welcome them to the ISTSS meeting.

Membership Information

Join now for 2009

ISTSS meeting registration does not include membership in ISTSS. If you are not already a member, consider joining the Society now at the registration desk located in the Bays 1-4 on the 4th floor. ISTSS membership includes the peer-reviewed *Journal of Traumatic Stress* and *Traumatic StressPoints*, the award-winning bi-monthly, online society newsletter. As an ISTSS member, you will also enjoy access to the "Members Only" section of the ISTSS Web site, which includes an online directory of all members, an invaluable resource for instant connection to an extensive network of trauma experts; discounts on use of the ISTSS Career Center; discounts on selected publications from Taylor and Francis, a leading source of trauma journals and texts and eligibility for recognition and awards presented by ISTSS to individuals who have made outstanding contributions to the field.

ISTSS members may participate in Special Interest Groups and committees. Your ISTSS membership plays an important role in supporting international trauma research and treatment. **ISTSS membership is based on a calendar year — January 1 through December 31 — and dues are not prorated.**

Bookstore for ISTSS — Exhibition Hall 4th Floor

Professional Books offers a large selection of trauma-related publications for sale during the meeting. Contact Professional Books at +1-617-630-9393, by e-mail: read9books@aol.com or visit www.professionalbooks.com.

Bookstore Hours:

The bookstore is open Wednesday from 10:30 a.m. – 5:30 p.m., Thursday, Friday and Saturday from 7:00 a.m. – 6:00 p.m.

Business Center — The UPS Store – 7th Floor

Copying, faxing, office supplies, computer and printer stations and other business services are available from the hotel business center, which is called "The UPS Store" with 24-hour access. Assistance is available Monday – Friday from 6 a.m. – 9 p.m., Saturday and Sunday from 8:00 a.m. – 4:00 p.m.

Committee Meeting Rooms

The Kimball, Logan, Madison and Marshfield rooms, located on the 3rd floor, are available for committee or small group meetings at designated times during the conference. Attendees can reserve meeting times by using the sign-up sheet outside each of the meeting rooms.

Exhibits — Exhibition Hall, 4th Floor

Thursday, November 13	7:00 a.m. – 6:00 p.m.
Friday, November 14	7:00 a.m. – 6:00 p.m.
Saturday, November 15	7:00 a.m. – 2:00 p.m.

Stop by the exhibits to see the display of products and services of interest in the trauma field. The exhibits provide valuable interaction between the profession and organizations that provide the products and services. A list of the exhibitors can be found in the on-site newsletter in registration packets.

Meeting Evaluation

ISTSS needs your input to enhance future ISTSS meetings. An online meeting evaluation survey will be e-mailed to you shortly after the ISTSS Annual Meeting. Your participation in this survey is greatly appreciated.

Message Center — Grand Ballroom Foyer 4th Floor

The ISTSS message center is located next to the registration desk in the Grand Ballroom Foyer/Registration Bay – 4th floor at The Palmer House Hilton. Messages for registrants are posted alphabetically by last name. Please remove your messages after you have received them. The ISTSS message center can be reached by calling the hotel operator at +1-312-726-7500 and ask to be transferred to the ISTSS registration desk.

ISTSS Multimedia CD-ROM Recordings

A multimedia CD-ROM will be produced for the educational benefit of attendees. In addition to the audio, PowerPoint® presentations provided by the presenters will also be included. Take home the meeting by ordering a CD-ROM at the exclusive onsite price of $69 for members and $89 for nonmembers, available only to those individuals attending the conference. The CD-ROM price will increase significantly after the conclusion of the conference. Your pre-ordered CD-ROM will be mailed to you within three weeks of the conclusion of the conference.

Restaurants

A list of local restaurants is included in your registration material.

Smoking Policy

Smoking is prohibited at any ISTSS function.

Speaker Ready Room — Cresthill – 3rd Floor

If you plan to use audiovisual aids during your presentation, visit the Speaker Ready Room before your presentation. The room is equipped with much of the same audio-visual setup as session rooms, so you may test your materials and rehearse your presentation.

Speaker Ready Room Hours:

The Speaker Ready Room is available Wednesday from 7:30 a.m. – 5 p.m., Thursday and Friday from 7:00 a.m. – 5:00 p.m. and Saturday from 7:00 a.m. to 3:30 p.m.

Special Assistance

Notify the ISTSS registration desk in Grand Ballroom Foyer/Registration Bay – 4th Floor, if you require special assistance at the conference.

Exhibitor Directory (at Press Time)

Alliant International University Institute on Violence, Abuse and Trauma

Table Number: 4
10065 Old Grove Road
San Diego, CA 92131
Phone: +1-858-527-1860 ext. 4050
Fax: +1-858-527-1743
E-mail: bgeffner@pacbell.net
Web Site: www.ivatcenters.org

Brochures and information about Alliant International University's Institute on Violence, Abuse and Trauma (IVAT), as well as information and sample journals from Taylor and Francis/Haworth Press' Trauma and Maltreatment Program. Additionally, flyers about IVAT's training program and conferences as well as a book list from its online bookstore are provided.

Children's National Medical Center

Table Number: 6
111 Michigan Ave, NW
Washington, DC 20010
Phone: +1-202-476-2434
Fax: +1-202-476-2368
E-mail: slewin@cnmc.org
Web Site: www.childrensnational.org/icttoc

The International Center to Heal Our Children provides information, training and outreach to communities coping with traumatic events. Our vision is to foster, promote and maintain the emotional health of children who have been psychologically traumatized by acts of violence, disasters or terrorism. Publications will be exhibited or visit www.childrensnational.org/ichoc.

Heartmath
Table Number: 3
14700 West Park Ave
Boulder Creek, CA 95006
Phone: +1-831-338-8781
Fax: +1-831-338-9861
E-mail: carol@heartmath.com
Web Site: www.heartmath.com

HeartMath provides a range of unique services, products, and technology to increase health and well-being while dramatically reducing stress. The emWave® technology and HeartMath system are currently being used by Duke Medical Center, Stanford, Kaiser, UNC, Blue Cross Blue Shield, Sutter Health and many other top medical centers to reduce stress, depression, fatigue, sleep problems and improve emotional fitness.

Sheppard Pratt Health System
Table Number: 5
6501 N Charles Street
Baltimore, MD 21204
Phone: +1-410-938-3157
Fax: +1-410-938-3159
E-mail: ifisher@sheppardpratt.org
Web Site: www.sheppardpratt.org

As a nationally recognized program at a top ten behavioral health facility, we offer treatment for all stages of psychological trauma recovery. Integrating an intensive multi-disciplinary approach through individual, milieu and process-oriented, experiential and psycho-educational group therapies, our expertly trained treatment teams provide a structured, supportive environment to facilitate stabilization.

Trauma Institute and Child Trauma Institute
Table Number: 2
PO Box 544
Greenfield, MA 01302
Phone: +1-413-774-2340
Fax: +1-413-772-2090
E-mail: cti@childtrauma.com
Web site: www.trauma.info / www.childtrauma.com

Trauma Institute & Child Trauma Institute provide consultation, on-site training and distance learning programs in trauma-informed treatment for mental health professionals and others. Web site: trauma.info and childtrauma.com.

Wiley-Blackwell
Table Number: 1
350 Main Street
Malden, MA 02148
Phone: +1-800-532-5954
Fax: +1-781-338-8552
E-mail: jeelliot@wiley.com
Web Site: www.wiley.com

Wiley-Blackwell, the scientific, technical, medical and scholarly publishing business of John Wiley & Sons, is the leading society publisher. We are proud to publish the *Journal of Traumatic Stress* on behalf of the ISTSS. For more information, visit www.wileyinterscience.com.

Special Events/Meetings

First-Time Attendees/New Members Gathering
Adams Ballroom – 6th Floor
Wednesday, November 12 7:00 p.m. – 8:00 p.m.
Experienced members of ISTSS will provide a framework for navigating the Annual Meeting and introduce participants to ISTSS as an organization. While geared toward first-time attendees, all ISTSS participants are invited to join in the discussions, ask questions, make comments and provide insight.

Cash Bar Meet and Greet **Monroe Ballroom – 6th Floor**
Wednesday, November 12 8:00 p.m. – 10:00 p.m.
The Meet and Greet provides a meeting place for all conference attendees.

Student Meeting **Red Lacquer – 4th Floor**
Thursday, November 13 12:30 p.m. – 1:45 p.m.
All students are invited to attend the annual student luncheon at the 24th ISTSS Annual Meeting. The ISTSS student leadership will report on the current status of the Student Section and provide information about student opportunities and benefits. The third annual Award for Outstanding Student Achievement will be presented at this time. Mary Fabri, PsyD, who serves as the director of the Marjorie Kovler Center of the Heartland Alliance for the Treatment of Survivors of Torture, is the Student Lunch guest speaker. The Heartland Alliance provides comprehensive services to survivors of officially sanctioned government or political torture who live in Chicago and the Midwestern part of the United States. Members of the Board of Directors have been invited to the luncheon and this gathering presents an excellent opportunity for networking with professionals in the field and fellow students. Pre-registered students will receive lunch which is paid for by ISTSS. All students must have registered for the Student Meeting on the registration form to be included in the lunch.

Internship and Program Networking Fair **Red Lacquer – 4th Floor**
Thursday, November 13 **2:00 p.m. – 3:15 p.m.**

Finding an internship or post-doctoral program that offers trauma-specific training can be difficult. In an attempt to ease this burden, the Student Section is offering this session to provide an opportunity for students to talk with representatives of various internship and/or post-doctoral programs who offer rotations or specializations in the clinical aspects of working with trauma. The training programs will have the opportunity to recruit potential interns or post-doctoral residents, while the students will have the opportunity to locate these programs and ask questions about the experiences offered. Programs from across the United States have been invited to represent a diversity of clinical interests. This networking session was organized by Lynnette Averill, Student Section vice chair and representative to the ISTSS Board of Directors.

Organizations Participating in the Internship and Post-Doctoral Program Networking Fair

- The Center for Traumatic Stress/Salem VA Medical Center/Salem, Virginia
- Durham VA Medical Center/Durham, North Carolina
- VA Maryland Health Care System/Baltimore, Maryland
- VA Palo Alto/Palo Alto, California
- VA Boston Healthcare System & Consortium, Boston Consortium in Clinical Psychology/Boston, Massachusetts
- University of California, Davis Medical Center (Pediatrics), CAARE Diagnostic and Treatment Center/Sacramento, California
- VA Salt Lake City Health Care System/Salt Lake City, Utah
- National Center for PTSD Pacific Islands Division/ Honolulu, Hawaii
- VA Pacific Islands Health Care System/Honolulu, Hawaii
- Southwest Consortium Pre-doctoral Psychology Internship, Substance Abuse, Trauma and Rehabilitation Residence (STARR), Jerry Murphy VA Medical Center/Albuquerque, New Mexico
- South Texas Veterans Health Care System/San Antonio, Texas
- Southern Arizona VA Health Care System/Tucson, Arizona
- VA Trauma Recovery Program/South Central MIRECC & University of Mississippi Medical Center/G.V. "Sonny" Montgomery VAMC Consortium/Jackson, Mississippi
- Coatesville VAMC/Coatesville, Pennsylvania
- Northwest Georgia Consortium Internship/Rome, Georgia
- VAMC/Battle Creek, Michigan
- PTSD and Anxiety Disorders Division/Cincinnati VA Medical Center/Cincinnati, Ohio
- New Orleans Department of Veterans Affairs Medical Center/New Orleans, Louisiana
- Hines VA Medical Center/Chicago, Illinois

ISTSS Annual Business Meeting **Adams Ballroom – 6th Floor**
Thursday, November 13 **6:15 p.m. – 7:15 p.m.**

All meeting participants are welcome. This is your opportunity to learn about the Society, ask questions and make suggestions. In addition to meeting ISTSS leadership, student poster awards will be presented and travel grant recipients will be announced.

Awards Ceremony **Adams Ballroom – 6th Floor**
Thursday, November 13 **7:15 p.m. – 8:00 p.m.**

Help us recognize the recipients of this year's awards from the International Society for Traumatic Stress Studies. Everyone is invited to attend the Awards Ceremony.

Welcome Reception **Grand Ballroom – 4th Floor**
Thursday, November 13 **8:00 p.m. – 11:00 p.m.**

All registered attendees are invited to attend the reception welcoming attendees to the 24th ISTSS Annual Meeting. The reception will be held immediately following the Awards Ceremony.

Dancing **State Ballroom – 4th Floor**
Thursday, November 13 **9:30 p.m. – 11:00 p.m.**

Join us for dancing from 9:30 to 11:00 p.m.

Meet the ISTSS Diversity Committee **Crystal Room– 3rd Floor**
Friday, November 14 **12:45 p.m. – 1:15 p.m.**

The ISTSS Diversity Committee is interested in your thoughts, opinions and questions about who we are as a Committee, diversity issues within ISTSS and more broadly, about diversity and traumatic stress studies. We are inviting all interested Annual Meeting participants to come meet us during the first part of the Diversity Special Interest Group meeting. We'll be discussing and developing our priorities for the coming year and how we, as a committee, can become more visibly responsive to the field and to ISTSS members. We welcome your input! If you have any questions, please contact Elisa Triffleman, chair of the Diversity Committee, at elisatriffleman@earthlink.net. Interested participants are also welcome to remain for the second half of the Diversity SIG meeting, during which speakers from the SIG- and Committee-sponsored symposium will be on hand.

ISTSS Special Interest Groups
Friday, November 14 **12:45 p.m. – 1:45 p.m.***
and Saturday, November 15 **12:45 p.m. – 1:45 p.m.***

The purpose of Special Interest Groups (SIGs) is to provide members with a forum for communication and interaction about specific topic areas related to traumatic stress, as well as providing a means of personal and professional involvement in the activities of the Society. All meeting participants are welcome to attend the SIG meetings. Lunch will **NOT** be provided. *See page 23 – 24 for a listing of specific SIG meetings for each day.

Play Reading: **Grand Ballroom –**
Achilles in Vietnam **4th Floor**
Friday, November 14 **8:00 p.m. – 9:30 p.m.**

J. Nicholas Schweitzer has adapted Jonathan Shay's best-selling book *Achilles in Vietnam: Combat Trauma and the Undoing of Character* as a stage play. You won't want to miss this performance!

Educational Need

"Terror and its Aftermath" encompasses the communication of scientific findings, practice and policy issues regarding the ways in which people respond to terror in diverse settings. Terror connotes both a state of extreme fear and the fact that there is usually a perpetrator using violence to intimidate or oppress. Specifically, speakers will focus on communicating scientific findings, practice and policy related to all aspects of this theme, including terrorism and terrorist violence, sexual and physical abuse within families, the terrorisation of one local community by another, organised repressive violence and torture by states and national groups, needs of responder groups including health, social care and education services, emergency services, the military and peace-keeping forces, the media, non-governmental organizations and pastoral care.

Speakers are strongly requested to avoid unnecessary jargon and to make their work and its implication to the traumatic stress field as accessible as possible to those who do not share their particular perspective and type of scientific approach. This is designed to facilitate increased understanding of what different types of research (e.g., basic scientists, clinical researchers) focusing on different types of traumatic stressors (e.g., child maltreatment, disasters, terrorism, war) using different research methods and perspectives (e.g., epidemiology, genetics, psychosocial, psychobiological) have found as well as what the implications of their work are for the traumatic stress field. Our aspirational goal is to establish a jargon-free zone in which experts maximize communication of their work, findings and implications in a way that facilitates understanding and cross-fertilization among researchers, clinicians, and policy makers from other perspectives.

Educational Objectives

Participants of the ISTSS Annual Meeting will be able to:

- Identify key risk factors for the development of emotional problems after traumatic event exposure
- Demonstrate knowledge of interventions aimed at survivors of terror-related trauma
- Describe key practice and policy-related issues relevant to preventing and intervening with survivors of diverse forms of terror

Target Audience

This meeting is appropriate for attorneys, counselors, educators, journalists/media experts, marriage and family therapists, nurses, physicians, policy makers, psychiatrists, psychologists, researchers, social workers, victims advocates and students interested in traumatic stress and the impact of terror on individuals, families and communities.

Continuing Medical Education

Accreditation

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of the Boston University School of Medicine and the International Society for Traumatic Stress Studies. Boston University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

Credit Designation

Boston University School of Medicine designates this educational activity for a maximum of 25.25 AMA PRA Category 1 Credit(s) ™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

CME Course Director

Danny Kaloupek, PhD, Boston University School of Medicine

Continuing Education Credit (non-MD)

The 24th ISTSS Annual Meeting is co-sponsored by The International Society for Traumatic Stress Studies and The Institute for Continuing Education. Continuing education credit is offered as listed below. All CE types offer 25.25 credit hours. (Hours for psychologists are 25.00.) If you have questions regarding continuing education, contact The Institute by phone, +1-251-990-5030; fax, +1-251-990-2665; or e-mail, instconted@aol.com.

Psychology: The Institute for Continuing Education is an organization approved by the American Psychological Association (APA) to sponsor continuing education for psychologists. The Institute for Continuing Education maintains responsibility for this program and its content.

Counseling: The Institute for Continuing Education is an NBCC-approved continuing education provider and a co-sponsor of this event. The Institute for Continuing Education may award NBCC approved clock/contact hours for programs that meet NBCC requirements. The Institute for Continuing Education maintains responsibility for this program and its content. NBCC Provider No. 5643.

Continuing Education Registration and Requirements

A certificate fee of $35 for members and $55 for non-members is required and can be applied for by checking the appropriate box on the registration form. You also may pay on site. However, you may not register for credits after November 15. Continuing education credit will be awarded on a session-by-session basis, with full attendance required for each session attended. To receive continuing education credit, attendees must sign in/sign out daily and complete the continuing education evaluation packet. **Stop by the continuing education desk before attending any sessions to receive your packet and to sign in/sign out daily.**

It is the responsibility of conference attendees who hold licensure with boards to contact their individual licensing jurisdiction to review current continuing education requirements for licensure renewal.

The following events/presentations are not available for continuing education credits: poster sessions, awards ceremony, opening reception, Internship and Post-doctoral Networking Fair, First-Time Attendees Meeting/New Members Gathering, Student Lunch, Special Interest Group Meetings, Play Reading and the Business Meeting.

Social Work: The Institute for Continuing Education is approved as a provider for continuing education by the Association of Social Work Boards (ASWB), through the Approved Continuing Education Program (ACE). Licensed social workers should contact their individual state jurisdiction to review current continuing education requirements for licensure renewal. The Institute for Continuing Education maintains responsibility for the program. ASWB Provider No. 1007.

- **Illinois Dept. of Professional Regulation: Social Work License:** 159-000606.
- **Ohio Board of Counselor/Social Work:** Provider No. RCS 030001.
- **California Board of Behavioral Sciences:** Provider PCE 636.
- **Florida Board:** BAP #255.

Marriage/Family Therapy: The Institute for Continuing Education is recognized as a provider of continuing education activities by most state boards of Marriage/Family Therapy.

Nursing: The Institute for Continuing Education is accredited as a provider of continuing education in nursing by the Alabama Board of Nursing, Provider No. 1124; and the California Board of Nursing, Provider No. CEP 12646. Nurses should contact their state board to determine if approval of this program through the Alabama and California Board of Nursing is acceptable for continuing education in their state.

Alcohol/Drug: The Institute for Continuing Education is approved by the National Association of Alcohol and Drug Abuse Counselors (NAADAC) to provide continuing education for alcohol and drug abuse counselors. NAADAC Provider No. 00243.

Ethics

The ISTSS conference offers some sessions focusing on ethical issues in practice and research. These sessions have been approved by the continuing education provider to offer credits in ethics. However, please note that ultimately it is the responsibility of the course participant and their licensing board to make sure that courses approved for ethics meet their specific requirements. In addition, any ethics sessions would not meet California requirements, unless of course, they are specific to California laws/regulations.

Workshop: Addressing Ethical Dilemmas of Trauma Mental Health in Contemporary Wars and Terrorism
November 13, 8:00 a.m. – 9:15 a.m.

- Identify instances of the application of trauma models to contemporary events and issues, and evaluate the appropriateness of these applications.
- Determine the personal, professional, institutional and humanitarian dimensions of mental health leadership and associated obligations that arise in relation to contemporary traumatic events.
- Apply the principles of professional ethics to contemporary situations in which traumatic stress theory has been proposed as an explanatory model, and identify appropriate professional roles and responsibilities.

Workshop: Conducting Ethical and Responsible Trauma-Focused Research With Special Populations
November 14, 11:00 a.m. – 12:15 p.m.

- Identify ethical issues and appraise the risks and benefits associated with trauma-focused research involving human subjects.
- Determine the unique ethical issues in and barriers to trauma-focused research with special populations.
- Apply workshop information to address ethical issues encountered when conducting research with trauma survivors.

Disclosure Policy

Boston University School of Medicine asks all individuals involved in the development and presentation of Continuing Medical Education (CME) activities to disclose all relationships with commercial interests. This information is disclosed to CME activity participants. Boston University School of Medicine has procedures to resolve any apparent conflicts of interest. In addition, faculty members are asked to disclose when any discussion of unapproved use of pharmaceuticals and devices takes place. Disclosures for the faculty members who submitted their responses after the printing of this final program will be announced in the Addendum.

Name	Disclosed Relationships
Baker, Dewleen G.	Consultant: Organon Data Analysis; Other: Pfizer small number of shares
Cohen, Judith	Grant/Research Support: NIMH, SAMH, SAMHSA, Abbott Laboratories, Easai, Shire; Speakers Bureau: Abbott; Other: Guilford Press book
Davis, Lori	Grant/Research Support: Abbott; Easai, Shire; Major Stockholder: Advanced Trauma Solutions, Inc.; Speakers Bureau: Abbott
Foa, Edna	Grant/Research Support: Pfizer, Solvay, Eli Lilly, SmithKlineBeecham, GlaxoSmithKline, Cephalon, Bristol Myers Squibb, Forest, Ciba Geigy, KaliDuphar, APA; Consultant: Acetelion Pharmaceuticals; Speakers Bureau: Pfizer, GlaxoSmithKline, Forest Pharmaceuticals, APA, Jazz Pharmaceuiticals
Ford, Julian	Major Stockholder: Advanced Trauma Solutions, Inc
Fraser, George	Speakers Bureau: Valeant Canada Ltd.
Greenberg, Neil	I am a full-time military employee however nothing I will say will be directed by the military
Hughes, Laurel	Temporary Contract With OR DHS (ended January 2008)
Joober, Rihda	Consultant: Pfeifer Canada, Jausseu Orhho
Katz, Lori	Owner, Innerwisdom Press
Lipke, Howard	I am sometimes paid to teach EMDR and have a book in print on the subject
Mavissakalian, Matig	Consultant: JAZZ Pharmaceuticals; Speakers Bureau: Pfizer
McMahon, Cait	Consultant: DART Center for Journalism Trauma
Najavits, Lisa	Lisa Najavits is director and owner of Treatment Innovations, which receives book royalties and consulting related to psychotherapy
Newman, Elana	Grant/Research Support: Dart Center for Journalism and Trauma
Neylan, Thomas	Consultant: Actelion, Sanofi, Takeda
Phillips, Katharine A.	Grant/Research Support: National Institute of Mental Health, FDA, American Foundation for Suicide Prevention, Forest Lab, UCB Pharma; Other: Butler Hospital, The Dept of Pychiatry and Human Behavior, The Warren Alpert Medical School of Brown University; American Psychiatric Inst. For Research and Education, Speaking Honorarian from Academic Institutions, Merck, Oxford University Press, Guilford Publications, Wrightson Biomedical Publishing, The Free Press
Rando, Therese A	Therese A. Rando Associates, LTD Employee
Rothbaum, Barbara	Grant/Research Support: Janssen; Consultant: Tikvah; Major Stockholder: Virtually Better, Inc; Speakers Bureau: Pri-Med
Ruzek, Josef	Trauma Tech (Grant/Research Support, Consultant, Major Stockholder, Research Collaboration)
Saxe, Glenn	Consultant: Child Service Solutions, LLC; Other: Guilford Press (book publisher/royalties)
Shalev, Arieh	Grant/Research Support: Lundbeck Pharmaceuticals
Shay, Jonathan	Author's royalty interest in two books on combat trauma that may be mentioned during session and are mentioned in literature citations
Sivak, Joseph	Speakers Bureau: Forrest, Astra Zeneca
Vermetten, Eric	Grant/Research: Lundbeck; Speakers Bureau: GSK
Zoellner, Lori	Grant/Research: R01 MH066347 (PI: Zoellner), Pfizer Inc. Medication Supply for MH066347

Additional disclosures are announced in the Addendum included in your on-site registration material.

Keynote Address

Thursday, November 13, 9:30 a.m. – 10:45 a.m.

Realpolitik and the Pursuit of International Criminal Justice: A Perennial Conflict?

M. Cherif Bassiouni, JD, LLB, LLM, SJD
Distinguished Research Professor of Law
DePaul University College of Law
Chicago, Illinois, USA

It is commonly said that "what is terrorism to some is heroism to others." Historically, states have benefited from the monopoly of violence to the exclusion of others. More recently, enhanced by globalization, individuals and small groups have effectively challenged states' monopoly on violence and have been able to use a strategy of low-level violence with considerable socio-psychological and political impact. At the same time, many governments have used fear in order to expand their powers and political durability by enhancing the public perception of vulnerability, in many instances violating or abridging individual civil rights, although these reactionary fear-tactics by governments have usually not proven to be effective.

The international legal regimes applicable to the regulation of collective violence are hopelessly mired in government politics. The law of armed conflict favors states against insurgent groups, even though the latter may have valid legitimacy claims. Conflicts of an internal character are outside the purview of the protection of international humanitarian law and thus favor incumbent governments irrespective of their illegitimacy. Other legitimate claims advanced by non-state actors find themselves without peaceful resolution mechanisms and thus appear to leave them only with the option of resorting to violence.

In reality, we need a genuinely modern international legal order to ensure that terror-violence is prevented and that all victims have access to systems of justice and redress. In this year of the 60th anniversary of the Universal Declaration of Human Rights, while applauding that visionary declaration, we need to review its impact through the last six decades, and apply its spirit to address the many issues involving our planet and its inhabitants today.

M. Cherif Bassiouni is a distinguished research professor of law at DePaul University College of Law and president of the International Human Rights Law Institute. He is also president of the International Institute of Higher Studies in Criminal Sciences in Siracusa, Italy, as well as the honorary president of the International Association of Penal Law (President 1989-2004), based in Paris, France.

He has served the United Nations in a number of capacities, including as: member and then chairman of the Security Council's Commission to Investigate War Crimes in the Former Yugoslavia (1992-94); Commission on Human Rights' independent expert on The Rights to Restitution, Compensation and Rehabilitation for Victims of Grave Violations of Human Rights and Fundamental Freedoms (1998-2000); vice-chairman of the General Assembly's Ad Hoc Committee on the Establishment of an International Criminal Court (1995); and chairman of the Drafting Committee of the 1998 Diplomatic Conference on the Establishment of an International Criminal Court. In 2004, he was appointed by the United Nations High Commissioner for Human Rights as the independent expert on the Situation of Human Rights in Afghanistan.

In 1999, Professor Bassiouni was nominated for the Nobel Peace Prize for his work in the field of international criminal justice and for his contribution to the creation of the International Criminal Court. He has received the following medals: Grand Cross of the Order of Merit (Commander), Federal Republic of Germany (2003); Legion d'Honneur (Officier), Republic of France (2003); Order of Lincoln of Illinois, United States of America (2001); Grand Cross of the Order of Merit, Republic of Austria (1990); Order of Sciences (First Class), Arab Republic of Egypt (1984); Order of Merit (Grand'Ufficiale), Republic of Italy (1977), and Order of Military Valor (First Class), Arab Republic of Egypt (1956). He has also received numerous academic and civic awards, including the Special Award of the Council of Europe (1990); the Defender of Democracy Award, Parliamentarians for Global Action (1998); The Adlai Stevenson Award of the United Nations Association (1993); and the Saint Vincent DePaul Humanitarian Award (2000).

Professor Bassiouni is the author of 27 and editor of 44 books, and the author of 217 articles on a wide range of legal issues, including international criminal law, comparative criminal law, and international human rights law. His publications have appeared in Arabic, Chinese, Farsi, French, Georgian, German, Hungarian, Italian, and Spanish. Some of these publications have been cited by the International Court of Justice, the International Criminal Tribunal for the Former Yugoslavia (ICTY), The International Criminal Tribunal for Rwanda (ICTR), the United States Supreme Court, as well as by several United States Appellate and Federal District Courts, and also by several State Supreme Courts.

Featured Sessions

Thursday, November 13, 2:00 p.m. – 3:15 p.m.
Concurrent Session 3

Trauma and Reparative Justice

(Abstract #196781)

Featured (Ethics, Media Ed)

Danieli, Yael, PhD[1]; Hirsch, Susan, PhD[2]; Mones, Paul, JD[3]; Laperrière, André, MBA[4]
[1]Group Project for Holocaust Survivors and Their Children, New York, New York, USA
[2]Institute for Conflict Analysis and Resolution, George Mason University, Arlington, Virginia, USA
[3]Attorney/Consultant, Portland, Oregon, USA
[4]The Trust Fund for Victims, Sainte-Foy, Quebec, Canada

Delineating the meaning of reparative justice in relation to other forms of justice, and beyond reparation per se, this multidisciplinary panel will convey, from the victims' and a lawyer's perspective, their experiences of justice. Missed opportunities and negative experiences in international justice will be examined as a means to better understand critical junctures of trials and victims' roles within the totality of the trial process to demonstrate that, if conducted optimally, the justice process can lead to opportunities for healing. Reparative justice clearly requires ongoing training of all professionals, be it judges, prosecutors, lawyers, interpreters, on all aspects of the courts' mandates related to victims, including self-care to counteract vicarious victimization.

Saturday, November 15, 8:00 a.m. – 9:15 a.m.
Concurrent Session 10

The Biology of PTSD

Making Relevant Animal Models for PTSD: Looking for Phenotypic Variation Rather Than Typical Response to Stress

(Abstract #198302)

Featured (Res Meth, Bio Med)

Yehuda, Rachel, PhD[1]

[1]*Mount Sinai School of Medicine, Bronx VA Medical School, Bronx, New York, USA*

The theoretical link between exposure to extreme stress and the development of PTSD provided the rationale for early hypotheses that PTSD-related biological alterations would be similar in direction to those observed acutely in animals exposed to stressors. When subsequent findings indicated that only a minority of trauma-exposed individuals develop PTSD an alternative hypothesis was generated proposing that PTSD involves a failure of mechanisms involved in recovery and restitution of physiological homeostasis, possibly resulting from individualistic predisposition. It has been challenging to interpret the extent to which biological alterations that are consistent with normative consequences of stress exposure in PTSD reflect pathogenesis.

This presentation will focus on attempts to develop animal models for PTSD based on the premise of examining individual differences to a uniform provocation that yields long-lasting biobehavioral consequences, analogous to those in PTSD. These strategies generally involve examination of biological underpinnings in phenotypic variation of differences in response to fear conditioning and other provocations and yield information addressing why only some persons exposed to trauma fail to recover.

Animal Models in PTSD: Their Contribution to Pharmacotherapy

(Abstract #198555)

Featured (Bio Med, Prev EI)

Zohar, Joseph, MD[1]

[1]*Psychiatric Department, The Chaim Shiba Medical Center Israel, Herzlia, Israel*

Although animal models of psychiatric disorders are limited to the assessment of measurable and observable behavioral parameters and cannot assess complex psychological symptoms such as thought, meaning and dreams, they are in some ways advantageous. Valid and reliable animal models may provide a means for researching biomolecular, pathophysiological and pharmacological features of the disorder in ways which are not feasible in human studies. PTSD provides a unique basis for an animal model since in PTSD, the trigger is well-known and universal—exposure to a traumatic event—and hence the center of gravity shifts from how to induce it to how to "diagnose" those animals who develop PTSD versus those who do not. The behavioral cut-off criteria were introduced, and based on this concept—setting apart the affected—we can isolate and study those animals who developed "PTSD-like behavior," comparing them to those who did not develop (although they were exposed) and to those who were not exposed.

Researchers who work with animals have long been aware that individual study subjects tend to display a varying range of responses to stimuli, certainly where stress paradigms are concerned. This heterogeneity in responses was accepted for many years and regarded as unavoidable. Since humans clearly do not respond homogeneously to potentially traumatic experiences, the heterogeneity in animal responses might be regarded as confirming the validity of animal studies, rather than as a problem. It stands to reason that a model of diagnostic criteria for psychiatric disorders could be applied to animal responses to augment the validity of study data, as long as the criteria for classification are clearly defined, reliably reproducible and yield results which conform to findings in human subjects. Of course, different study paradigms may give rise to different sets of criteria.

This animal model enables us to test interventions that might be impossible (i.e. Anisomycin) or difficult (e.g. BNZ, SSRI, Cortisol) to do in a clinical setting without any proper preclinical basis. Results from interventions given at specific timepoints (either immediately after exposure or much later) in a group of rats that were followed prospectively will be presented. Their implications on potential pharmacological approaches will be discussed, with emphasis on three examples. One is early administration of SSRI, the second, early administration of cortisol and the long-term consequences. Thirdly, the early or late administration of cortisol in different dose regimens will be presented in the talk.

This featured session introduces a morning of biology-related presentations.

Saturday, November 15, 2:00 p.m. – 3:15 p.m.
Concurrent Session 13

Soldiers at War: The Perspectives of Two Journalists

Addressing PTSD in Combat Troops Returning From Iraq and Afghanistan

(Abstract #198509)

Featured (Mil Emer, Media Ed)

Kennedy, Kelly[1]

[1]*Times News Service, Alexandria, Virginia, USA*

An embedded reporter's personal experiences covering the wars in Iraq and Afghanistan will be presented. Specifically, the implications of sanitizing media coverage of war will be discussed. It will be argued that unless the details of the experiences are reported, a disservice is being done not only to service members, but also to their families, communities, and health-care workers. Society has an excuse to believe PTSD is nothing more than a loss of courage or people trying to get over on the system by seeking benefits. With the details, it is hard to wonder how anyone could come out of such a situation unscathed.

How Iraq Veterans are Fighting the Next War Here in America

(Abstract #198511)

Featured (Soc Ethic, Mil Emer)

McKelvey, Tara[1]

[1]*The American Prospect, Washington, District of Columbia, USA*

A look at the deeply scarred generation of U.S. service members returning from the war in Iraq and the degree to which the government is neglecting their care here at home.

Master Clinician Series

Thursday, November 13, 8:00 a.m. – 9:15 a.m.
Concurrent Session 1

Ghosts and Angels in the Nursery: Curtailing the Transmission of Trauma From Parents to Children

(Abstract #198318)

Master (Child, Clin Res)

Lieberman, Alicia, PhD[1]

[1]*University of California San Francisco, San Francisco, California, USA*

There is empirical evidence that children aged birth-five become traumatized by exposure to repeated family and community violence and show developmentally specific manifestations of traumatic stress. Early trauma treatment presents special challenges because the child's traumatic stress is compounded by the parents' traumatic response. This presentation will describe the manifestations of traumatic stress in infants, toddlers and preschoolers and the intergenerational transmission of traumatic stress from parent to child. It will also describe Child-Parent Psychotherapy (CPP), a relationship-based treatment where parents' unresolved traumatic experiences are integrated with their experiences of feeling safe and protected to generate adaptive parenting strategies that promote the child's attachment security and emotional health. The presentation will include CPP theoretical background, clinical modalities, and case illustrations, as well as empirical evidence of efficacy from randomized controlled trials. Cultural considerations in the treatment of children and families from diverse ethnic, racial, and socioeconomic backgrounds will be discussed.

Thursday, November 13, 3:30 p.m. – 4:45 p.m.
Concurrent Session 4

Cognitive Therapy for Posttraumatic Stress Disorder

(Abstract #197588)

Master (Practice, Clin Res)

Clark, David, DPhil[1]

[1]*King's College London, Institute of Psychiatry, London, United Kingdom*

Ehlers and Clark (2000) proposed a cognitive model of the development and maintenance of PTSD that specifies three main therapeutic targets. These are: 1) reducing re-experiencing by elaborating the trauma memory and discriminating between current triggers and cues that were present at the time of the trauma; 2) identifying and modifying excessively negative appraisals of the trauma and/or its sequelae; and 3) dropping problematic maintaining cognitive and behavioural strategies. A novel cognitive therapy (CT) programme that specifically focuses on these targets was developed and tested in four randomized controlled trials and two dissemination studies. Taken together these studies show that the treatment is: acceptable to patients (low drop-out rate), effective (large controlled effect sizes relative to no-treatment), and specific (superior to an alternative, equally credible psychosocial treatment). The trials have established the treatment's efficacy for PTSD following single and multiple traumatic events in adulthood including those arising from civil conflict and terrorism. The dissemination studies have shown that the treatment can be transported to everyday community clinical settings without loss of effectiveness. Finally, an intensive version of the treatment that concentrates the therapeutic work into a single week has been developed and shown to be similarly effective.

This presentation describes and illustrates the key therapeutic maneuvres in CT for PTSD. The overall treatment program includes elements that are common in other empirically validated CBT programmes (e.g. imaginal reliving and cognitive restructuring) as well as novel features. The presentation concentrates on the more novel features which are illustrated with video tapes of live treatment sessions. Key maneuvres include: 1) identifying triggers for intrusive memories and discriminating between these triggers and the original trauma using experiential work; 2) working on linking trauma hot spots with updating information and facilitating elaboration; 3) re-scripting intrusive images and 4) dealing with a wide range of problematic behavioural and cognitive strategies.

Participant Alert: Video tapes of treatment sessions in which patients exhibit distress will be shown.

Friday, November 14, 8:00 a.m. – 9:15 a.m.
Concurrent Session 5

Integrating Human Rights Principles Into Clinical Practice: Working With Refugees and Asylum Seekers

(Abstract #198266)

Master (Civil Ref, Cul Div)

Steel, Zachary, M.Clin.Psych, BA (Hons)[1]

[1]*Macquarie University, Sydney, New South Wales, Australia*

In both Western countries and in the developing world, refugee and asylum seekers face multiple ongoing threats to their mental health and well being. Many of these challenges are a direct result of state polices of deterrence which breech fundamental human rights principles. The clinician working with these populations must face these difficulties if they are to provide support, care and treatment to their clients. This workshop explores how an understanding of human rights principles can help the clinician in their therapeutic work in these and other settings. The three broad generations of human rights: civil and political rights; economic, social, and cultural rights; and group and collective rights will be reviewed. The position of the therapist is rendered more complex as he or she is also a member of the society that is responsible for the human rights violations experienced by their clients. Threats within each of these broad domains can, thus, not only directly affect the client but undermine the therapeutic relationship. The experience of clinicians in Australia over the previous decade has underscored the need to understand clinical practice within a broader socio-political context. Similarly the experience of clinicians working in post-conflict environments underscores the need to develop a broader understanding of clinical care and treatment. By way of case example the workshop will illustrate the dangers facing the clinician who fails to take account of the broader human rights context of treatment. The final section will demonstrate practical steps for integrating core human rights principles and analysis into cognitive behavioural clinical formulations and treatment.

This Master Clinician session will be followed by a morning of paper presentations relating to refugees.

Friday, November 14, 2:00 p.m. – 3:15 p.m.
Concurrent Session 8

Eye Movement Desensitization and Reprocessing: Clinical Case Presentation

(Abstract #197560)

Master (Practice, Clin Res)

Solomon, Roger, PhD[1]

[1]*Buffalo Center for Trauma and Loss, Buffalo, New York, USA*

Eye Movement Desensitization and Reprocessing (EMDR) is an integrative psychotherapeutic approach that conceptualizes current symptoms resulting from experiences that are inadequately processed; that is, "frozen" in the brain. When these inadequately stored memories are triggered, symptoms result (e.g. nightmares, flashbacks, intrusive thoughts, etc.). The EMDR protocol involves accessing the dysfunctionally stored information, stimulating the innate processing system through standardized protocols (including eye movements), allowing it to transmute the memory to an adaptive resolution. Processing is evident by a rapid progression of intrapsychic connections as emotions, insights, sensations and memories surface and change with each new set of bilateral stimulation. The mechanisms of action include adaptive information from other memory networks linking into the network holding the dysfunctionally stored information. There is a shifting of the information from implicit to episodic and then semantic memory. The memory is no longer isolated, and becomes appropriately integrated within the larger memory network. Hence, processing involves the forging of new associations and connections enabling learning to take place with the memory stored in a new adaptive form.

This presentation will discuss the eight phases, three-pronged, EMDR treatment model and illustrate the dynamics of treatment through a video case presentation.

Participant Alert: A taped session with a client who has experienced trauma will be presented.

This Master Clinician session will be followed by a workshop on using EMDR with traumatic bereavement.

Saturday, November 15, 8:00 a.m. – 9:15 a.m.
Concurrent Session 10

Treating Complex Trauma in Older Adolescents and Adults: The Self-Trauma Model

(Abstract #197587)

Master (Practice, Clin Res)

Briere, John, PhD[1]

[1]*Keck School of Medicine, University of Southern California, Los Angeles, California, USA*

Recent research indicates that trauma-related disturbance can be quite complex. When trauma exposure involves early, repetitive, interpersonal maltreatment, or when there have been multiple and prolonged traumas in adulthood, the outcome may involve not only classic posttraumatic stress and related dysphoria, but also dysfunctional attachment styles, altered relational schema, affect dysregulation, overdeveloped avoidance responses (especially substance abuse, dissociation and tension reduction behaviors) and conditioned cognitive-emotional responses.

This presentation will outline the central aspects of a cognitive-behavioral/relational approach to complex trauma in older adolescents and adults, referred to as the Self-Trauma Model (STM). The STM is a customized, components-based intervention that involves (a) carefully titrated exposure to traumatic material as it arises (or is elicited) during treatment, as opposed to a formal exposure hierarchy or focus on a single traumatic memory, (b) cognitive consideration of archaic trauma-related beliefs and expectations, (c) the development of increased self-capacities (especially identity and affect regulation) so that avoidance behaviors such as substance abuse or tension reduction activities are less necessary for psychological equilibrium and (d) the reworking of activated relational schema and other implicit memories within the therapeutic relationship. Although most of the components of STM have been empirically validated, the overall model varies considerably according to the specific needs of each client. As a result, the STM is not manualized on a session-by-session basis. However, there is an associated text for its application: *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment* (Briere & Scott [2006]). Videotaped vignettes with an actress will be played at various points in this presentation to illustrate the implementation of specific treatment components.

This Master Clinician session will be followed by symposia discussing complex trauma issues.

Saturday, November 15, 2:00 p.m. – 3:15 p.m.
Concurrent Session 13

Treating Acute Stress Disorder

(Abstract #197561)

Master (Prev Ei, Clin Res)

Bryant, Richard, PhD[1]

[1]*University of New South Wales, School of Psychology, Sydney, New South Wales, Australia*

Acute stress disorder (ASD) describes initial stress reactions that are predictive of chronic posttraumatic stress disorder (PTSD). Since the September 11 terrorist attacks, there has been renewed international interest in early identification of acutely traumatized people and evidence-based intervention strategies. This masterclass will commence with an outline of the optimal ways to identify people shortly after trauma who are likely to develop long-term PTSD. The masterclass will provide a review of current assessment tools, as well as interactive discussion of strategies for assessing acutely traumatized individuals. A detailed outline of cognitive behaviour therapy strategies will be provided. Obstacles to treatment will also be discussed in the context of case studies.

Friday, November 14, 8:00 a.m. – 9:15 a.m.
Concurrent Session 5

DSM-V
Introduction to the Anxiety Disorders *DSM-V* Process

An Update on the *DSM-V* Development Process
(Abstract #196612)

(Assess Dx, Practice)

Phillips, Katharine, MD[1]; Friedman, Matthew, MD[2]
[1]Chair, Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Work Group Member, DSM-V *Task Force; Professor of Psychiatry and Human Behavior, Butler Hospital and the Alpert Medical School of Brown University, Providence, Rhode Island, USA*
[2]National Center for PTSD, Dartmouth Medical Center, White River Junction, Vermont, USA

The development of *DSM-V* is under way. This presentation will discuss important groundwork that has been laid for the development of *DSM-V*, including white papers that have been published (*A Research Agenda for DSM-V*) and *DSM-V* research planning conferences that have been held in recent years. The current status of the *DSM-V* development process will be described. In addition, some of the key considerations that are guiding the development of *DSM-V*—such as attention to gender and cross-cultural issues, developmental considerations, and the psychiatric/general medical interface—will be discussed.

Where Does PTSD Fit in the Overall Classification System?

Should PTSD Continue to be Classified as an Anxiety Disorder?
(Abstract #198262)

(Assess Dx, Res Meth)

Resick, Patricia, PhD[1],
[1]National Center for PTSD, VA Boston Healthcare Systems, Boston, Massachusetts, USA

Posttraumatic stress disorder has been classified as an anxiety disorder since its inception in 1980. On one hand, this classification is logical because of the level of fear that often accompanies traumatic events, the conditioning that appears to occur with previously neutral cues, and the influence of avoidance on the maintenance of the disorder. On the other hand, there is also evidence that fear may not be the best predictor of who does or does recover from traumatic events such that a diagnosis of PTSD is warranted, and does not capture the array of other emotions such as anger, shame, sadness, or grief that may also accompany the disorder or even predominate in many cases. This talk will describe where PTSD falls with recent efforts to factor analyze Axis I diagnoses and will review studies that attempt to predict who will develop PTSD following trauma, to examine the question of whether PTSD is truly an anxiety disorder or should be classified elsewhere.

Is PTSD a Stress-Induced Fear Circuitry Disorder?
(Abstract #197880)

(Bio Med, Assess Dx)

Shin, Lisa, PhD[1]
[1]Tufts University, Department of Psychology, Medford, Massachusetts, USA

To address the question of whether PTSD is a stress-induced fear circuitry disorder, this presentation will summarize recent relevant functional neuroimaging findings in PTSD. Many recent studies have reported hyperresponsivity in the amygdala and dorsal anterior cingulate cortex, and hyporesponsivity in the ventral medial prefrontal cortex in PTSD. Recent research using a monozygotic twin design has suggested that exaggerated glucose metabolism and MRI activation in the dorsal anterior cingulate is a familial risk factor for the development of PTSD after psychological trauma. In summary, several brain regions in the "fear network" appear to function abnormally in PTSD, and functional abnormalities in one of these regions (dACC) appear to act as a familial risk factor. Future research using twin and longitudinal designs will be needed to determine whether other functional abnormalities act as risk factors versus acquired signs of PTSD.

Participant Alert: Participant distress is extremely unlikely. Some participants who dislike viewing MRI images of the brain may be uncomfortable viewing such images in this presentation.

Should PTSD be Included in a New Cluster of Post-Event Psychiatric Disorders?
(Abstract #198300)

(Assess Dx, Practice)

Keane, Terence, PhD[1]
[1]VA National Center for PTSD, Boston University School of Medicine, Boston, Massachusetts, USA

Over the past thirty years, we've entertained the inclusion of PTSD in the overarching categories of Anxiety Disorders and Mood Disorders. New data are emerging that suggest that PTSD belongs in neither category; it shares some characteristics in common with each. PTSD also shares characteristics with personality disorders and with dissociative identity disorders. The current presentation focuses on the need for reconsidering the matter entirely. PTSD might well be included in a distinct category of conditions that are roughly viewed as post-event psychiatric disorders. A rationale for this model will be presented as will data supporting the creation of a new overarching category that will encompass several extant psychiatric conditions under this diagnostic category. Evidence will be drawn from psychometric studies, from neurobiological studies, longitudinal cohort research, and behavioral genetics. The importance of viewing trauma symptomatology as dimensional, secondary to recent taxonometric studies will be highlighted.

Friday, November 14, 9:30 a.m. – 10:45 a.m.
Concurrent Session 6

DSM-V
Why are Some People More Likely to Get PTSD Than Others?

Child and Adolescent Traumatic Stress and PTSD: A Developmental Perspective

(Abstract #198301)

(Assess Dx, Child)

Pynoos, Robert, MD, PhD[1]

[1]*University of California – Los Angeles School of Medicine, Los Angeles, California, USA*

The diagnostic category of PTSD has permitted our field to give scientific voice to the legacy of trauma for children and adolescents. It has also provided an important opportunity for the developmental investigation of its strengths and limitations, and consideration of treatment implications and testing of intervention strategies across developmental stages. Adopting a developmental perspective in further strengthening the diagnosis will provide an important vantage point on the following issues: 1) the theoretical and conceptual framework underlying PTSD, making use of new knowledge in developmental neurobiology and genetics; 2) the evolving appraisal and response to danger; 3) the construct and factor analysis of PTSD, especially in regard to symptom profile; 4) the role of associated intense negative emotions, for example, shame and guilt; 5) the role of ongoing preoccupation with protection and intervention thoughts; 6) co-morbid considerations, including the intersection of childhood PTSD with anxiety disorders and depression; and 7) the interplay with disturbances in developmental competencies. There is a critical need to complement assessment of functional impairment with equal attention to developmental impairment, including trauma-related disturbances in achieving developmental competencies and reaching developmental milestones. In addition, children are at risk of exposure to traumatic losses that require assessment of a range of traumatic grief reactions and their intersection with posttraumatic stress reactions and co-morbid conditions. Overall, prior *DSM* criteria have given only limited attention to developmental considerations which need to have a much more prominent place in *DSM-V.* Selected findings from the National Child Traumatic Stress Network Core Data Set that relate to these challenges will be included in this presentation.

Gene-Environment Interaction in Posttraumatic Stress Disorder

(Abstract #197569)

(Bio Med, Res Meth)

Koenen, Karestan, PhD[1]

[1]*Harvard University School of Public Health, Department of Society, Human Development, Boston, Massachusetts, USA*

The purpose of this presentation is to encourage research investigating the role of measured gene-environment interaction (GxE) in the etiology of posttraumatic stress disorder (PTSD). PTSD is uniquely suited to the study of GxE as the diagnosis requires exposure to a potentially-traumatic life event. PTSD is also moderately heritable; however, the role of genetic factors in PTSD etiology has been largely neglected both by trauma researchers and psychiatric geneticists. First, we summarize evidence for genetic influences on PTSD from family, twin and molecular genetic studies. Second, we discuss the key challenges in GxE studies of PTSD and offer practical strategies for addressing these challenges and for discovering replicable GxE for PTSD. Finally, we propose some promising new directions for PTSD GxE research. We suggest that GxE research in PTSD is essential to understanding vulnerability and resilience following exposure to a traumatic event.

Epigenetics and PTSD: A New Frontier in PTSD Risk and Implications for *DSM-V*

(Abstract #198156)

(Bio Med, Asses Dx)

Yehuda, Rachel, PhD[1]

[1]*Mount Sinai School of Medicine, Bronx VA Medical School, Bronx, New York, USA*

The study of epigenetic modifications of DNA may provide important insights into PTSD risk and pathophysiology since it provides a mechanism for explaining functional changes in genomic activity (as opposed to structural changes associated with different allelic variations or gene polymorphisms) that can be induced by environmental events. These functional changes can even be transmitted intergenerationally (e.g., via maternal behavior) which may provide critical insight for why PTSD runs in families. Indeed, when considering that PTSD is fundamentally a response to an environmental event that is likely formed, not so much by the objective characteristics of the event, but by subjective interpretations of its meaning, it becomes obvious that neither genetic analysis alone, nor an understanding of the normative biological responses to stress or fear, can provide the information that explains why PTSD results in only a proportion of those exposed. The study of epigenetics may, in particular, provide a relatively stable measure that reflects early life events rather than the cumulative effects of stress that can help delineate developmental influences on biological alterations in PTSD from those reflecting pathophysiology. The implications for epigenetic contributions to diagnostic issues in PTSD will be discussed.

Diagnostic Overlap Between PTSD and MDE in Two American Indian Populations: Implications for *DSM-V*

(Abstract #197567)

(Assess Dx, Cul Div)

Beals, Janette, PhD[1]

[1]*American Indian and Alaska Native Programs, University of Colorado – Denver, Aurora, Colorado, USA*

Psychiatric epidemiology has come of age in the past 30 years. Landmark studies have provided for essential descriptions of the prevalence of common *DSM*-defined disorders, including PTSD. Yet, parallel efforts for important subpopulations have lagged; resulting not only in a dearth of data about groups that may be at special risk, but also neglecting an opportunity to examine the consequences for our common nosologies in culturally diverse settings. The American Indian Service Utilization, Psychiatric Epidemiology, Risk, and Protective Factors Project (AI-SUPERPFP) was designed to assess the epidemiology of common mental health problems in two culturally diverse American Indian tribal groups using state-of-the-art methods. Perhaps the most interesting finding from this effort was a "crossover" between PTSD and major depressive episode (MDE) in the lay-administered interviews, whereby PTSD was found to be more common than in the general U.S. population, yet MDE was less common. At the same time, when clinicians interviewed a subset of those in the lay-administered sample, the pattern of findings was reversed (MDE more common than PTSD). In this presentation we will explore the implications of these findings for both *DSM-V*, generally, and for psychiatric epidemiology, in particular.

Friday, November 14, 11:00 a.m. – 12:15 p.m.
Concurrent Session 7

DSM-V
Examining the Construct Validity of PTSD and ASD

Factor Structure of PTSD: Implications for *DSM-V*

(Abstract #197962)

(Assess Dx, Res Meth)

Palmieri, Patrick, PhD[1]

[1] *Summa-Kent State Center for the Treatment and Study of Traumatic Stress, Summa Health System and Kent State University, Akron, Ohio, USA*

The diagnostic criteria for Posttraumatic Stress Disorder (PTSD) have undergone considerable revision since the category was first established in the *DSM-III*. In terms of symptom criteria, the *DSM-IV* describes 3 symptom clusters that are intended to reflect the underlying dimensions of PTSD. These clusters include 5 re-experiencing (e.g., intrusive thoughts; nightmares), 7 avoidance (e.g., avoidance of thoughts, feelings, or conversations; emotional detachment), and 5 hyperarousal (e.g., difficulty sleeping; exaggerated startle response) symptoms related to exposure to one or more traumatic events. The original criteria as well as the revisions, however, were made primarily on rational grounds, leaving questions about the validity of this 3-factor model unanswered.

Confirmatory factor analysis (CFA) is well suited for answering questions about structural validity. Accordingly, many CFA studies have been published in the past 10 years evaluating plausible structural models of PTSD in both military and civilian trauma samples. By far the most consistent finding has been the lack of empirical support for the *DSM-IV* 3-factor model. Among alternative models, two 4-factor models have garnered the most support. The emotional numbing model specifies the same re-experiencing and hyperarousal factors as the *DSM-IV* 3-factor model, but separates the avoidance factor into distinct effortful avoidance and emotional numbing factors. The dysphoria model specifies the same re-experiencing and avoidance factors as the emotional numbing model, but re-casts the emotional numbing symptoms and three of the five hyperarousal symptoms as indicators of a dysphoria, or general distress, factor and views the two remaining symptoms as indicators of a purer hyperarousal factor. Results demonstrate clearly that the *DSM-IV* avoidance symptoms do not reflect a coherent avoidance factor, a fact that any proposed revision to the diagnostic criteria must address.

Research and discussion in the following areas will help guide specific revisions to the PTSD diagnostic criteria: 1) more model invariance testing across samples, instruments, and time; 2) more assessment of construct validity of factors in good fitting models; 3) using additional indicators of putative factors to better cover factor space and yield more stable factor solutions; 4) including indicators of associated factors (e.g., guilt); 5) studying if psychogenic amnesia (which usually has low factor loadings) needs to be assessed differently, or whether it is even an essential feature of PTSD; 6) examining whether linking symptoms to an index trauma versus trauma in general affects model fit; and 7) examining whether different definitions of trauma affect model fit.

PTSD and the Internalizing/Externalizing Model of Comorbidity

(Abstract #197566)

(Assess Dx, Bio Med)

Miller, Mark, PhD[1]

[1]*National Center for PTSD, VA Boston Healthcare System, Boston University School of Medicine, Boston, Massachusetts, USA*

This presentation will review evidence for a model of the structure of posttraumatic psychopathology which suggests that patterns of comorbidity and other clinical correlates of PTSD are organized by temperament-based propensities towards internalizing versus externalizing disorders. A theoretical framework for conceptualizing the structure and etiology of patterns of PTSD comorbidity will be presented along with evidence to support the model. Implications for conceptualizing heterogeneity among trauma survivors will be discussed along with recommendations for PTSD biomarker identification and treatment matching.

Acute Stress Disorder in *DSM-V*

(Abstract #198002)

(Assess Dx, Prev El)

Bryant, Richard, PhD[1]

[1]*University of New South Wales, School of Psychology, Sydney, New South Wales, Australia*

Acute stress disorder (ASD) describes initial stress reactions that occur in the initial month after trauma and purportedly predictive of chronic posttraumatic stress disorder (PTSD). There has been much debate about the utility of this disorder. First, it has been criticized because it resembles PTSD in many regards apart from the timeframe. Second, the emphasis placed on dissociation has been challenged by numerous studies. Third, prospective studies of children and adults have shown that the majority of people who develop PTSD do not initially have ASD. The accumulating evidence challenges the utility of the ASD diagnosis and demonstrates that it is not a useful means to identify people shortly after trauma who will develop PTSD. Accordingly, this review will argue that there is insufficient evidence to include ASD in *DSM-V*.

Friday, November 14, 2:00 p.m. – 3:15 p.m.
Concurrent Session 8

DSM-V
Should There be a Complex Trauma Diagnosis in *DSM-V?*

Developmental Trauma Disorder: Towards a Rational Diagnosis of the Sequelae of Chronic Childhood Abuse and Neglect

(Abstract #198507)

(Assess Dx, Res Meth)

van der Kolk, Bessel, MD[1]
[1]*Boston University School of Medicine, Trauma Center, Boston, Massachusetts, USA*

Purpose: Each year over 3,000,000 children are reported to the authorities for abuse and/or neglect in the US. Research has well documented that adverse childhood experiences have a powerful relation to adult health a half-century later and expressed as increased depression, suicide attempts, alcoholism, drug abuse, sexual promiscuity, domestic violence, obesity, and a variety of physical illnesses. Childhood trauma is probably our nation's single most important public health challenge.

Method: While isolated traumatic incidents tend to produce discrete conditioned behavioral and biological responses to reminders of the trauma, as captured in the PTSD diagnosis, chronic maltreatment has well-documented and pervasive effects on the development of mind and brain. This workshop will present convergent data from 10 different data bases comprising over 100,000 children that document consistent problems with affect regulation, dissociation, cognition, and interpersonal relationships that are not captured in the PTSD diagnosis. Some of these problems are currently captured by a variety of different *DSM* "co-morbid" diagnoses.

Conclusion: We will conclude with provisional diagnostic criteria for Developmental Trauma Disorder as formulated by the NCTSN *DSM-V* Task force.

What is Complex About Complex PTSD and Does it Matter for Treatment?

(Abstract #197963)

(Assess Dx, Clin Res)

Cloitre, Marylene, PhD[1]
[1]*New York University Child Study Center, Institute for Trauma & Stress, New York, New York, USA*

Complex PTSD has been defined as arising from exposure to prolonged and multiple traumatic stressors, typically of an interpersonal nature and often in childhood, that inflict harm to the physical or psychic integrity of the person (e.g., childhood abuse, neglect, domestic violence, being taken hostage, witness to or target of genocide). Such experiences can result in self-regulatory disturbances which include not only PTSD symptoms but also self-destructive and impulsive behaviors, substance abuse, chronically impaired relationships with others, dissociation, and somatic and identity disturbances. While it has been argued that these problems can be readily captured through the designation of one or more co-morbid psychiatric disorders, many of the symptoms do not reach threshold for such a designation and thus fall "under the radar" for formal identification and consequently, effective treatment. This presentation will offer data indicating that (1) increased type of traumatic exposures, particularly in childhood is associated with increasingly complex symptom profiles and (2) the accumulation of various self-regulatory symptom clusters as defined above (and that do not meet criteria for a psychiatric disorder) significantly contribute to functional impairment. Treatment implications will be discussed.

Dissociation and the Complex Trauma Reactions

(Abstract #198501)

(Assess Dx, Practice)

Vermetten, Eric, MD, PhD[1]
[1]*Military Mental Health – Research Center, Utrecht, Netherlands*

Traumatic dissociation has a long tradition that has seen a come and go in psychiatry. The psychiatric approach to the dissociative disorders for a long time failed to acknowledge any relationship to psychological trauma. Before *DSM-III* dissociation was grouped with the old remnant of hysteria, conversion disorder, and called "dissociative hysteria." Due to this, the dissociative disorders had difficulty shaking the suspicion that they were not true disorders, or that they were a disguise for secondary gain, malingering, or criminality. In 1980, the dissociative disorders were separated from hysterical neurosis and gained independent status. Since then PTSD and the dissociative disorders have developed in a somewhat parallel fashion. Its link with trauma has given dissociation an opportunity to be examined in relation with PTSD studies. Contemporary psychological and psychiatric sciences have used the term dissociation to denote alterations in conscious experience, a breakdown in integrated information processing and psychological functioning and the operation of multiple independent streams of consciousness. As a response to threat, it manifests as a kind of body/mind problem that reflects in dysregulated brain functions that are rooted in critical developmental periods of life. Neuroimaging studies have shown neural systems which play an key role in emotion, and autonomic nervous system regulation, sensory processing, attention and memory that exhibit altered levels of brain activation during dissociation, and are different from responses of 'simple' intrusions and hyperarousal—each representing unique pathways to chronic stress-related psychopathology. The phenomenology of traumatic dissociation is recognized in acute 'narrowly defined' posttrauma reactions, but is also seen in cases classified as complex PTSD. Dissociation can be both symptom or a disorder, or a descriptive of a vulnerable phenotype. The complexity of trauma responses is revealed not in the complexity of the trauma, but in the multitude or spectrum of response types in which dissociative symptoms, but also depressive and somatization symptoms, substance abuse, eating disorders as well as general anxiety symptoms are present.

Friday, November 14, 3:30 p.m. – 4:45 p.m.
Concurrent Session 9

DSM-V
Should the Trauma Criteria be Retained or Revised?

The Criterion A Problem: On the Past, Present and Future of the Stressor Criterion for PTSD

(Abstract #197922)

(Assess Dx, Res Meth)

Weathers, Frank, PhD[1]
[1]*Auburn University, Department of Psychology, Auburn, Alabama, USA*

Considerable controversy has surrounded Criterion A, the stressor criterion for posttraumatic stress disorder (PTSD), since PTSD was first introduced in *DSM-III* in 1980. This presentation will summarize the various issues, challenges, empirical findings and proposed solutions regarding the appropriate role of Criterion A. The following points will be argued: First, psychological trauma is difficult to define, and the goal of achieving a succinct, unambiguous, universally accepted definition may be unrealistic. Second, although Criterion A has evolved considerably since *DSM-III*, the underlying conceptualization of trauma has remained stable. Third, when the criterion language and accompanying text are considered together, the *DSM-IV* version of Criterion A provides a practical definition of trauma that provides a sufficiently stringent threshold of stressor severity while allowing for requisite clinical judgment. Fourth, Criterion A is essential to the current conceptualization of PTSD as a stress-related disorder and crucial for differential diagnosis of PTSD, especially vis-à-vis adjustment disorder. Finally, many of the anomalous empirical findings concerning trauma exposure and PTSD are likely the result of insufficiently specific assessment methods. Suggestions will be offered regarding revision of Criterion A for *DSM-V* and methodological improvements in assessment of trauma and PTSD.

Defining Criterion A: Philosophical and Empirical Controversies

(Abstract #197593)

(Assess Dx, Res Meth)

Kilpatrick, Dean, PhD[1]
[1]*Medical University of South Carolina, Department of Psychiatry, Charleston, South Carolina, USA*

The stressor criterion, or Criterion A, plays a major gate-keeping role in the PTSD diagnosis because it determines which events qualify to be evaluated with respect to other PTSD criteria. How broadly or narrowly Criterion A should be defined has generated controversy since the birth of the PTSD diagnosis, and each revision of the diagnosis has included a different definition of Criterion A. In particular, the *DSM-IV* definition of Criterion A has been criticized as facilitating "bracket creep" (McNally & Breslau, 2008). This presentation will argue that the controversy over how Criterion A should be defined involves philosophical as well as empirical questions. The philosophical question is whether there is utility in excluding some types of stressor events from Criterion A if they are demonstrated to be capable of producing sufficient PTSD symptoms to meet Criterion B, C, D and F. The empirical question is whether "bracket creep" is a real or a pseudo problem. If there is a substantial increase of PTSD prevalence defined as meeting Criteria, B, C, D, E, and F when stressors do not meet the Criterion A1 and/or A2 definition, then there would be empirical support for the "bracket creep" argument. However, if there is little change in PTSD prevalence when such stressor events are included, "bracket creep" would be a pseudo problem from an empirical perspective. A second empirical question is how to measure PTSD when an individual has been exposed to numerous potentially traumatic events and other stressors. These questions will be addressed using two large epidemiological national probability household samples of U.S. young adults and adolescents in which exposure to potentially traumatic events, other life stressors, and PTSD symptomatology were measured. Implications for changes in the Criterion A definition will be discussed.

Traumatic Events Should Meet Either Criterion A1 or A2, Not Both

(Abstract #197571)

(Assess Dx, Bio Med)

Brewin, Chris, PhD[1]
[1]*University College – London, Clinical, Educational and Health Psychology, London, United Kingdom*

Stressor criterion A2 was added to the *DSM-IV* so that in order to qualify for a diagnosis of PTSD, potentially traumatic events had to fulfill both objective and subjective criteria. Research with crime victims has shown that extreme fear, helplessness or horror often, but not invariably, accompany events leading to PTSD. Delayed onset PTSD in military samples is associated with less extreme subjective responses to trauma than cases of immediate onset PTSD while otherwise being indistinguishable in terms of symptom profile. In contrast, A2 responses are sometimes associated with the full PTSD symptom profile in the absence of an event that would meet the objective criterion A1. This is to be expected given what is known about the ability of stress responses to be sensitised biologically by exposure to early or repeated trauma. A solution that could be implemented in *DSM-V* is for potentially traumatic events to be required to meet either criterion A1 or A2, rather than having to meet both criteria as they do at present.

Do We Need Criterion A2?

(Abstract #197592)

(Assess Dx, Res Meth)

Schnurr, Paula, PhD[1]
[1]*VA National Center for PTSD, White River Junction, Vermont, USA*

In *DSM-IV*, the stressor criterion was modified in order to ensure that an individual who qualified for a diagnosis of PTSD had experienced a potentially traumatic event as traumatic. In essence, the modification—A2—was to serve a gate-keeping function by preventing over-diagnosis among trauma survivors who had not had a serious subjective reaction to an event. In practice, there has been little need for a gate. The *DSM-IV* Field Trial data showed prevalence varied little as a function of whether the A2 Criterion was applied. Other data show that although meeting A2 in the immediate aftermath of a trauma predicts the development of PTSD, it is the absence of A2 that matters: although a number of people who meet A2 do not go on to develop PTSD, relatively few who fail to meet A2 will develop PTSD. This presentation will examine the argument that A2 is unnecessary for diagnosis, and will include discussion of how the absence of a strong subjective reaction can be useful in other contexts, such as predicting the need for future services. The presentation will also include discussion of definitional issues, including whether other strong reactions such as shock or numbing should be included.

ISTSS 2008 Award Recipients

The ISTSS Awards Committee, chaired by Josef Ruzek, PhD, would like to announce the 2008 ISTSS Award Recipients. Please join us at the Awards Ceremony, Thursday, November 13 from 7:15 to 8 p.m., in the Adams Ballroom, 6th floor, to help honor the following distinguished ISTSS award recipients:

Lifetime Achievement Award
This award is the highest honor given by ISTSS. It is awarded to the individual who has made great lifetime contributions to the field of PTSD.
2008 Recipient: Dean Kilpatrick, PhD

Robert S. Laufer Award for Outstanding Scientific Achievement
This award is given to an individual or group who has made an outstanding contribution to research in the PTSD field.
2008 Recipient: Naomi Breslau, PhD

Public Advocacy Award
This award is given for outstanding and fundamental contributions to advancing social understanding of trauma.
2008 Recipient: Ellen Gerrity, PhD

Sarah Haley Memorial Award for Clinical Excellence
This award is given to a clinician or group of clinicians in direct service to traumatized individuals. This written and/or verbal communication to the field must exemplify the work of Sarah Haley.
2008 Recipient: Charles Zeanah, Jr., MD

Chaim and Bela Danieli Young Professional Award
This award recognizes excellence in traumatic stress service or research by an individual who has completed his or her training within the last five years.
2008 Recipient: Richard Meiser-Stedman, PhD

Frank Ochberg Award for Media and Trauma Study
This award recognizes significant contributions by clinicians and researchers on the relationship of media and trauma.
2008 Recipient: Roger Simpson, PhD

ISTSS Special Interest Groups

The purpose of Special Interest Groups (SIGs) is to provide members with a forum for communication and interaction about specific topic areas related to traumatic stress, as well as providing a means of personal and professional involvement in the activities of the Society. All meeting participants are welcome to attend the SIG meetings. Lunch will not be available for purchase. Attendees should bring their own lunch if planning to eat during the SIG meetings. A list of dining options is included in your registration materials.

The Diversity SIG is extending a personal invitation to all interested Annual Meeting participants to join this SIG during the first part of the Diversity Special Interest Group meeting to share their ideas. The Diversity SIG will meet on Friday, as indicated below.

Friday, November 14, 12:45 p.m. – 1:45 p.m.	**Room**
Diversity and Cultural Competence	Crystal Room
Human Rights and Social Policy	Salon 1
Intergenerational Transmission of Trauma and Resilience	Salon 2
Media	Salon 3
Military	Salons 4-6
Research Methodology	Salons 7-9
Spirituality	Monroe Ballroom
Terrorism and Bioterrorism Related Trauma	Wabash Room
Trauma Assessment and Diagnosis	State Ballroom

Saturday, November 15, 12:45 p.m. – 1:45 p.m.	**Room**
Child Trauma	Crystal Room
Complex Trauma	Salon 1
Creative Body and Energy Therapies	Salon 2
Early Interventions	Salon 3
Family Systems Approaches to Trauma	Salons 4-6
Internet and Technology	Salons 7-9
Primary Care and Trauma	Monroe Ballroom
Psychodynamic Research and Practice	Wabash Room
Traumatic Loss and Complicated Grief	State Ballroom

See page 56 for Special Interest Groups NOT scheduled to meet at time of printing.

The following is a list of presentations that are endorsed by the ISTSS Special Interest Groups. An endorsement indicates that the SIG has determined this presentation is particularly relevant to their specific topic areas.

Complex Trauma

Wednesday, November 12, 1:30 p.m. – 5:00 p.m.	PMI#15: Treating Resistant PTSD: Cognitive Behavior Therapy for Complex Trauma
Friday, November 14, 2:00 p.m. – 3:15 p.m.	*DSM-V*: Should There be a Complex Trauma Diagnosis in *DSM-V*?
Saturday, November 15, 8:00 a.m. – 9:15 a.m.	Master Clinician: Treating Complex Trauma in Older Adolescents and Adults: The Self-Trauma Model

Diversity and Cultural Competence

Thursday, November 13, 3:30 p.m. – 4:45 p.m.	Symposium: Not to Forget Culture – Studies on the Development of PTSD
Friday, November 14, 9:30 a.m. – 10:45 a.m.	*DSM-V*: Diagnostic Overlap Between PTSD and MDE in Two American Indian Populations
Friday, November 14, 11:00 a.m. – 12:15 p.m.	Paper: Refugee Mental Health
Saturday, November 15, 3:30 p.m. – 4:45 p.m.	Symposium: Low Income and Ethnic Minority Women: Multiple Trauma and Effects, Culturally Sensitive Treatment

Early Interventions

Thursday, November 13, 2:00 p.m. – 3:15 p.m.	Symposium: The First Blueprint for International Mass Casualty Intervention: 5 principles to Guide Intervention and Research
Saturday, November 15, 8:00 a.m. – 9:15 a.m.	Symposium: Optimizing Survey and Experimental Methods in PTSD Prevention Trails
Saturday, November 15, 11:00 a.m. – 12:15 p.m.	Symposium: Addressing Child Trauma in Pediatric Medical Settings

Family Systems Approaches to Trauma

Thursday, November 13, 8:00 a.m. – 9:15 a.m.	Master Clinician: Ghosts and Angels in the Nursery: The Transmission of Trauma From Parents to Children
Friday, November 14, 2:00 p.m. – 3:15 p.m.	Paper: Post-Deployment Adjustment in Veterans Treating Veterans and Their Families
Saturday, November 15, 9:30 a.m. – 10:45 a.m.	Workshop: Family Informed Trauma Treatment Model

Human Rights and Social Policy

Thursday, November 13, 8:00 a.m. – 9:15 a.m.	Workshop: Addressing Ethical Dilemmas of Trauma Mental Health in Contemporary Wars and Terrorism
Thursday, November 13, 11:00 a.m. – 12:15 p.m.	Symposium: The Nature and Extent of Traumatic Stress in Refugees
Saturday, November 15, 3:30 p.m. – 4:45 p.m.	Symposium: Torture and Mental Health: What is Torture, and How Should Professional Organizations Respond?
Saturday, November 15, 3:30 p.m. – 4:45 p.m.	Symposium: Mental Health of War-Affected Youth in Two Conflicts: The Role of the Family, Community and Classroom

Intergenerational Transmission of Trauma and Resilience

Thursday, November 13, 8:00 a.m. – 9:15 a.m.	Master Clinician: Ghosts and Angels in the Nursery: Curtailing the Transmission of Trauma From Parents to Children
Friday, November 14, 9:30 a.m. – 10:45 a.m.	*DSM-V*: Epigenetics and PTSD: A New Frontier in PTSD Risk and Implications for *DSM-V*
Friday, November 14, 11:00 a.m. – 12:15 p.m.	Media: ISTSS on Sesame Street: Helping Military Families Cope With Deployment and War Injury

Media

Saturday, November 15, 11:00 a.m. – 12:15 p.m.	Media: New Media and Trauma – Candid Views From Australasian Journalists
Saturday, November 15, 2:00 p.m. – 3:15 p.m.	Featured: Soldiers at War: The Perspectives of Two Journalists Addressing PTSD in Combat Troops Returning From Iraq and Afghanistan

Military

Wednesday, November 12, 8:30 a.m. – Noon	PMI#10: Preventing Psychological & Moral Injury in Military Service: Misconduct Combat Stress Behaviors
Wednesday, November 12, 1:30 p.m. – 5:00 p.m.	PMI#13: The Warrior as Patient: Engaging, Assessing, and Treating the Returning Veteran
Friday, November 14, 3:30 p.m. – 4:45 p.m.	Paper: Treatment Issues in Combat-Related Stress

Research Methodology

Thursday, November 13, 11:00 a.m. – 12:15 p.m.	Symposium: Applying Innovative Technologies in Trauma Research and Clinical Practice
Friday, November 14, 11:00 a.m. – 12:15 p.m.	Workshop: Conducting Ethical and Responsible Trauma-Focused Research With Special Populations
Friday, November 14, 2:00 p.m. – 3:15 p.m.	Symposium: Innovations in Experimental Psychopathology Research

ISTSS Special Interest Groups

Spirituality

Thursday, November 13, 8:00 a.m. – 9:15 a.m.	Symposium: Integrating Spirituality in Training and Care
Friday, November 14, 3:30 p.m. – 4:45 p.m.	Symposium: Applying Mindfulness-Based Interventions for Trauma Across Diverse Populations
Saturday, November 15, 9:30 a.m. – 10:45 a.m.	Symposium: Mindfulness, Meditation, and CBT: Similarities and Differences

Terrorism and Bioterrorism Related Trauma

Wednesday, November 12, 8:30 a.m. – noon	PMI 5: After Terrorist Events: Innovative Disaster Mental Health Systems of Care, Planning – Implementation
Wednesday, November 12, 8:30 a.m. – noon	PMI 6: Building Resilience in the Shadow of War and Terror: A School-Based Ecological Intervention Model
Thursday, November 13, 8:00 a.m. – 9:15 a.m.	Workshop: Terror-Related PTSD: Which Treatment Works? What Defines Treatment Success? What Defines Failure?

Trauma Assessment and Diagnosis

Thursday, November 13, 2:00 p.m. – 3:15 p.m.	Symposium: Symptom Clusters, Comorbidities, Provider Detection and Deferential Weighted Health Status of PTSD
Friday, November 14, 9:30 a.m. – 10:45 a.m.	Workshop: Assessing Readjustment From OIF/OEF Using the Post-Deployment Readjustment Inventory
Friday, November 14, 3:30 p.m. – 4:45 p.m.	*DSM-V*: Should the Trauma Criteria be Retained or Revised?

Traumatic Loss and Complicated Grief

Wednesday, November 12, 1:30 p.m. – 5:00 p.m.	PMI #11: Skills for Psychological Recovery
Friday, November 14, 8:00 a.m. – 9:15 a.m.	*DSM-V:* Should PTSD Continue to be Classified as an Anxiety Disorder?
Friday, November 14, 9:30 a.m. – 10:45 a.m.	*DSM-V:* Child and Adolescent Traumatic Stress and PTSD: A Developmental Perspective
Friday, November 14, 3:30 p.m. – 4:45 p.m.	Workshop: Utilization of EMDR With Traumatic Bereavement

Note: Presentation endorsements were not submitted by the following SIGs: Child Trauma, Gender and Trauma and Internet & Technology.

Affiliate Societies of ISTSS

Affiliate Societies of ISTSS: African Society for Traumatic Stress Studies (AfSTSS), Argentine Society for Psychotrauma (SAPsi), Association de Langue Francaise pour l'Etude du Stress et du Traumatisme (ALFEST), Australasian Society for Traumatic Stress Studies (ASTSS), Canadian Traumatic Stress Studies Network (CTSN), Deutschsprachige Gesellschaft Für Psychotraumatologie (DeGPT), European Society for Traumatic Stress Studies (ESTSS), Japanese Society for Traumatic Stress Studies (JSTSS)

The following is a list of presentations that are endorsed by the Affiliate Societies of ISTSS. An endorsement indicates that the Affiliate Society has determined this presentation is of particular relevance and/or interest to their organization:

Association de Langue Francaise pour l'Etude du Stress et du Traumatisme (ALFEST)

Thursday, November 13, 11:00 a.m. – 12:15 p.m.	Symposium: Psychological Outcome of Motor Vehicle Accidents
Thursday, November 13, 2:00 p.m. – 3:15 p.m.	Paper: Novel Interventions for PTSD
Friday, November 14, 2:00 p.m. – 3:15 p.m.	Symposium: Dissociation and the Complex Trauma Reactions

Australasian Society for Traumatic Stress Studies (ASTSS)

Wednesday, November 12, 9:30 a.m. – 10:45 a.m.	PMI#17: Trauma Systems Therapy: Treating Traumatized Children in the System-of-Care
Friday, November 14, 8:00 a.m. – 9:15 a.m.	Master Clinician; Integrating Human Rights Principles Into Clinical Practice; Working With Refugees and Asylum Seekers
Friday, November 14, 9:30 a.m. – 10:45 a.m.	*DSM-V:* Why Are Some People More Likely to Get PTSD Than Others? Child and Adolescent Traumatic Stress and PTSD: A Developmental Perspective

European Society for Traumatic Stress Studies (ESTSS)

Thursday, November 13, 2:00 p.m. – 3:15 p.m.	Symposium: Brief Eclectic Psychotherapy for PTSD: New Evidence
Thursday, November 13, 3:30 p.m. – 4:45 p.m.	Master Clinician; Cognitive Therapy for Posttraumatic Stress Disorder
Friday, November 14, 8:00 a.m. – 9:15 a.m.	Symposium: The European Network for Traumatic Stress: Evidence Based Practice for Disaster Victims in Europe

Deutschsprachige Gesellschaft Für Psychotraumatologie (DeGPT)

Thursday, November 13, 11:00 a.m. – 12:15 p.m.	Symposium: Complex Trauma in Children and Adolescents: Conceptualization and Assessment

Japanese Society of Traumatic Stress Studies (JSTSS)

Thursday, November 13, 11:00 a.m. – 12:15 p.m.	Symposium: Psychological Outcome of Motor Vehicle Accidents
Saturday, November 15, 11:00 a.m. – 12:15 p.m.	Symposium: Impact of Catastrophic Events on First Responders and Children

Note: Presentation endorsements were not submitted by the following Affiliate Societies: African Society for Traumatic Stress Studies (AfSTSS), Argentine Society for Psychotrauma (SAPsi) and the Canadian Traumatic Stress Studies Network (CTSN).

Tuesday, November 11

		Room	Floor
4:00 p.m. – 6:00 p.m.	Registration Open	Grand Ballroom Foyer	4

Wednesday, November 12

7:30 a.m. – 8:30 a.m.	Coffee and Tea	State Ballroom Foyer	4
7:30 a.m. – 5:00 p.m.	Registration Open	Grand Ballroom Foyer	4

Wednesday, November 12, 8:30 a.m. – Noon and 1:30 p.m. – 5:00 p.m.

		Presentation Level	Keywords	Room	Floor	Page #
PMI – 1	Trauma-Focused CBT for Children: Intermediate Level *(Cohen, Mannarino)*	A	Child, Practice	Salon 1	3	50
PMI – 2	Acceptance and Commitment Therapy: Bringing Values to Life Following Trauma *(Walser, Westrup)*	M	Practice, Mil Emer	Salons 4 – 6	3	50
PMI – 3	Treatment of Prolonged Exposure Therapy (PE) *(Foa, Hembree)*	A	Clin Res, Practice	State Ballroom	4	50

Wednesday, November 12, 8:30 a.m. – Noon

PMI – 4	The Interface Between Trauma and OCD: Clinical Issues *(Winston)*	M	Practice, Assess Dx	Crystal Room	3	51
PMI – 5	After Terrorist Events: Innovative Disaster Mental Health Systems of Care, Planning—Implementation *(Gurwitch, Schreiber, Perez, Coady, Hughes, Derrickson)*	M	Disaster, Commun	Salon 2	3	51
PMI – 6	Building Resilience in the Shadow of War and Terror: A School-Based Ecological Intervention Model *(Baum, Pat-Horenczyk, Brom)*	M	Prev EI, Child	Salon 3	3	51
PMI – 7	Current Psychopharmacological Treatment of PTSD and the Psychological Underpinnings of the Treatment Alliance *(Sivak)*	M	Practice, Bio Med	Salons 7 – 9	3	52
PMI – 8	Somatic Intervention: Using the Trauma Resiliency Model (TRM) in the Treatment of Complex Trauma *(Leitch, Miller-Karas)*	M	Practice, Cul Div	Monroe Ballroom	6	52
PMI – 9	Acceptance and Commitment Therapy for Posttraumatic Anger-Related Problems in Living *(Santanello, Kelly)*	M	Practice, Mil Emer	Adams Ballroom	6	52
PMI – 10	Preventing Psychological & Moral Injury in Military Service: Misconduct Combat Stress Behaviors *(Shay, Greenberg, March, Nash, Stokes, Castro, Grenier)*	M	Prev EI, Mil Emer	Wabash Room	3	53

Presentation Type Descriptions

Cases/Workshops: Presentations that use an individual case or a series of cases to illustrate important clinical, theoretical or policy issues / didactic presentations that offer practical experience to increase understanding and skill in a particular area

DSM-V: Special one-day track focusing on the *DSM-V* development process and PTSD

Featured: Presentations invited by the program chair on topics of general interest related to the annual conference

Master Clinician: Demonstrations by expert clinicians of particular therapeutic approaches

Media Presentations: Sessions to present films, videotapes, music artwork and other forms of media relevant to traumatic stress

Panels/Symposiums: Presentations that provide the opportunity for discussion of diverse approaches by people working in related areas / groups of presentations that related to a common theme, issue or questions

Paper Presentations: Paper presentations are individual presentations on a wide variety of subjects related to traumatic stress. Paper presentations will be grouped in fours

Posters: Individual presentations in a poster forum on a wide variety of subjects related to traumatic stress

Pre-Meeting Institutes (PMIs): Half- or full-day programs that provide intensive introductory, intermediate or advanced training on topics related to traumatic stress

Wednesday, November 12

		Room	Floor
10:30 a.m. – 5:30 p.m.	Bookstore Open	Exhibtion Hall	4

Wednesday, November 12, 1:30 p.m. – 5:00 p.m.

		Presentation Level	Keywords	Room	Floor	Page #
PMI – 11	**Skills for Psychological Recovery** *(Watson, Ruzek, Vernberg, Layne, Berkowitz, Jacobs)*	I	Disaster, Prev EI	Crystal Room	3	54
PMI – 12	**Group Applications of Cognitive Processing Therapy** *(Chard, Rodgers)*	M	Practice, Clin Res	Salon 2	3	54
PMI – 13	**The Warrior as Patient: Engaging, Assessing, and Treating the Returning Veteran** *(Scurfield, Platoni, Rasmussen, Lighthall)*	I	Mil Emer, Practice	Salon 3	3	54
PMI – 14	**Beyond Exposure Alone: Brief Eclectic Psychotherapy for PTSD** *(Meewisse, Gersons, Schnyder, De Vries, Kitchiner, Nijdam)*	M	Practice, Media Ed	Salons 7– 9	3	54
PMI – 15	**Treating Resistant PTSD: Cognitive Behavior Therapy for Complex Trauma** *(Cloitre, Jackson)*	M	Clin Res, Practice	Monroe Ballroom	6	55
PMI – 16	**Somatic Therapies for Traumatic Stress** *(van der Kolk)*	M	Practice, Clin Res	Adams Ballroom	6	55
PMI – 17	**Trauma Systems Therapy: Treating Traumatized Children in the System-of-Care** *(Saxe)*	M	Child, Practice	Wabash Room	3	55

Wednesday, November 12

		Room	Floor
7:00 p.m. – 8:00 p.m.	New Member/First-Time Attendee Gathering	Adams Ballroom	6
8:00 p.m. – 10:00 p.m.	Cash Bar Meet and Greet	State Ballroom	4

Thursday, November 13

		Room	Floor
7:00 a.m. – 8:00 a.m.	Coffee and Tea	Exhibition Hall	4
7:00 a.m. – 5:00 p.m.	Registration Open	Grand Ballroom Foyer	4
7:00 a.m. – 6:00 p.m	Bookstore/Exhibits Open	Exhibition Hall	4

Presentation Level

All presentations designate the knowledge/skill level required of the participant as either: Introductory (I), Intermediate (M) or Advanced (A). These should be used as a general guide only since attendees have very diverse educational and professional backgrounds.

Introductory (I): Presentations that all participants (including undergraduate students) with any appropriate background will be able to fully comprehend and/or appreciate. Presentations will discuss concepts that are considered basic skills/knowledge for those working in the field.

Intermediate (M): Presentations that participants may more fully comprehend/appreciate if they have at least some work experience in the topic to be discussed.

Advanced (A): Presentations that present concepts which require a high-level of previous educational background, or work experience, in the particular area/topic to be discussed as well as being most geared for specialists and those in advanced stages of their career.

Keyword Type Descriptions

Sessions will be presented on a wide variety of topics identified by keywords:

1. Assessment/Diagnosis (Assess Dx)
2. Biological/Medical (Bio Med)
3. Children and Adolescents (Child)
4. Civilians in War/Refugees (Civil Ref)
5. Clinical or Interventions Research (Clin Res)
6. Clinical Practice Issues (Practice)
7. Community Programs (Commun)
8. Culture/Diversity (Cul Div)
9. Disaster/Mass Trauma (Disaster)
10. Media/Training/Education (Media Ed)
11. Military/Emergency Services/Aid workers (Mil Emer)
12. Prevention/Early Intervention (Prev EI)
13. Research Methodology (Res Meth)
14. Social Issues/Public Policy/Ethics (Soc Ethic)

Thursday, November 13, 8:00 a.m. – 9:15 a.m.
Concurrent Session 1

		Presentation Level	Keywords	Room	Floor	Page #
Master Clinician	**Ghosts and Angels in the Nursery: Curtailing the Transmission of Trauma From Parents to Children** *(Lieberman)*	**M**	**Child, Clin Res**	**State Ballroom**	**4**	**57**
Media Presentation	**ISTSS on Sesame Street: Helping Military Families Cope With Deployment and War Injury** *(Kudler, Fried, Albeck, Fairbank)*	**I**	**Media Ed**	**Crystal Room**	**3**	**57**
Symposium/Panel	**New Directions in Neuroimaging Studies of PTSD** *(McFarlane, Lanius, Brewin, Vermetten)* Working Memory and PTSD: A Neural Network Model of PTSD Default Network Abnormalities in PTSD: A fMRI Investigation Neural Correlates of Reliving in PTSD Regulation of Brain Activity in PTSD	**A**	**Bio Med, Res Meth**	**Grand Ballroom**	**4**	**57**
Symposium/Panel	**Dissemination of Two Evidence-Based PTSD Treatments in the Veterans Health Administration** *(Resick, Foa, Ruzek, Karlin)* Disseminating Cognitive Processing Therapy in VA: The Advantages and Challenges of a National Training Initiative Disseminating Prolonged Exposure Therapy (PE) in VA: Challenges, Barriers, and Successes Bringing Prolonged Exposure Treatment Into the Real-World of VA PTSD Care	**M**	**Media Ed, Practice**	**Adams Ballroom**	**6**	**58**
Symposium/Panel	**Integrating Spirituality in Training and Care** *(Lyons, Eriksson, Drescher, David)* Honoring Diversity of Beliefs in Group Therapy in an Academic Setting: Decision Points Religion as a Barrier and Resource in Trauma Treatment Spiritual/Moral Challenges of Combat: Helping Military Service Members Make Meaning of War Traumas	**M**	**Cul Div, Practice**	**Salon 2**	**3**	**59**
Symposium/Panel	**Social and Cognitive Determinants of Recovery After Trauma** *(Benight, Cieslak, Littleton, Nuttman-Shwartz, Fauterbach)* Social Support and Sexual Assault Recovery: The Mediating Role of Coping Coping Self-Efficacy Mediates the Effects of Negative Cognitions on Posttraumatic Distress The Contribution of Ways of Coping and Sense of Belonging to the College in Times of Ongoing Terror Cross-Sectional and Longitudinal Predictors of Trauma Responsiveness and Symptom Persistence	**I**	**Clin Res, Prev EI**	**Wabash Room**	**3**	**59**
Symposium/Panel	**Gathering and Implementing Evidence on Psychological Interventions to Prevent and Treat PTSD** *(Bisson, Roberts, Kitchiner)* Multiple Session Early Psychological Intervention to Prevent and Treat PTSD: A Cochrane Review Cochrane Review of Psychological Treatments for Chronic PTSD Trauma Focused Psychological Therapies in the Cardiff and Vale NHS Traumatic Stress Service	**M**	**Clin Res, Prev EI**	**Salons 4 – 6**	**3**	**60**
Symposium/Panel	**Elucidating the Relationship Between Substance Use and PTSD: Perspectives From the Lab to the Clinic** *(Waldrop, Kaysen, Owens, Lewis)* PTSD, Drug Abuse, and Risky Behavior in Women Alcohol Problems and the Course of Posttraumatic Stress Disorder in Female Crime Victims Relationships Among Substance Abuse History, Anger, and PTSD for Veterans in Residential Treatment	**M**	**Assess Dx, Clin Res**	**Monroe Ballroom**	**6**	**61**

Search for Presentations

The entire educational program and all meeting events, along with each session's learning objectives, are available online at http://www.istss.org/meetings/index.cfm. Use this online tool to search for presentations by keywords, presenters and much more. Visit the ISTSS Web site for additional instructions.

		Presentation Level	Keywords	Room	Floor	Page #
Thursday, November 13, 8:00 a.m. – 9:15 a.m.						
Concurrent Session 1						
Paper Presentations	Interpersonal Violence			**Salons 7 – 9**	**3**	**62**
	Exposure to Assault Violence *(Johansen)*	**M**	**Practice, Assess Dx**			**62**
	Self-Medication of PTSD by an Amphetamine-Like Substance: Effect on Paranoia in Somali Ex-Combatants *(Elbert)*	**M**	**Mil Emer, Assess Dx**			**62**
	Correlates of Symptom Reduction in Treatment Seeking Survivors of Torture *(Raghavan)*	**I**	**Civil Ref, Clin Res**			**62**
Workshop/ Presentation	**Addressing Ethical Dilemmas of Trauma Mental Health in Contemporary Wars and Terrorism** *(Stone, Weine, Henderson)*	**M**	**Soc Eth, Civil Ref**	**Salon 3**	**3**	**62**
Workshop/ Case Presentation	**Creating a Statewide Trauma-Informed System of Care** *(Franks, Lang)*	**M**	**Soc Eth, Commun**	**Salon 1**	**3**	**63**
Thursday, November 13, 9:30 a.m. – 6:00 p.m.						
Poster Session 1 Open				**Exhibition Hall**	**4**	
Thursday, November 13, 9:30 a.m – 10:45 a.m.						
Keynote Address	**Realpolitik and the Pursuit of International Criminal Justice: A Perennial Conflict?** *(Bassiouni)*			**Grand Ballroom**	**4**	**64**
Thursday, November 13, 11:00 a.m. – 12:15 p.m.						
Concurrent Session 2						
Symposium/Panel	**Recent Developments in PTSD Treatment Outcome Research** *(Resick, Rothbaum, Foa, Bryant)*	**I**	**Clin Res, Practice**	**Wabash Room**	**3**	**64**
	Pretreatment Predictors of Treatment Response Across Two Studies of Cognitive Behavioral Treatment for PTSD					
	Efficacy of the Developmentally Adjusted Prolonged Exposure Protocol With Post-Traumatic Youth: Comparing Victims of Terrorist Attacks With Victims of MVA					
	Predictors of Treatment Response for EMDR and Prolonged Exposure					
	Neural Predictors of CBT Response					
Symposium/Panel	**Complex Trauma in Children and Adolescents: Conceptualization and Assessment** *(Bryant, Nader, Ford, Briere, Pelcovitz, van der Kolk)*	**M**	**Chilld, Assess Dx**	**State Ballroom**	**4**	**65**
	Is a Complex PTSD Diagnosis Needed and Justified?					
	Do We Need a Child Complex Trauma Diagnosis, or Instead, a Way to Diagnose Ongoing Attachment Symptoms Beyond Age 5?					
	Can Complex PTSD be an Adolescent Onset Problem?					
	A Study of Developmental Trauma Disorder by the NCTSN *DSM-V* Task Force					
Symposium/Panel	**The Nature and Extent of Traumatic Stress in Refugees** *(Hinton, Rasmussen, Nickerson, de Jong)*	**M**	**Assess Dx, Civil Ref**	**Crystal Room**	**3**	**66**
	Key Idioms of Psychological Distress Among Cambodian Refugees					
	Idioms of Psychological Distress Among Darfuri Refugees					
	Mental Health and Postmigration Adjustment in the Mandaean Refugees in Sydney, Australia: A Longitudinal Study					
	The Effectiveness and Cost Effectiveness of Western Style Treatments in Non-Western Community Settings					

Thursday, November 13, 11:00 a.m. – 12:15 p.m.
Concurrent Session 2 (continued)

		Presentation Level	Keywords	Room	Floor	Page #
Symposium/Panel	**Psychological Outcome of Motor Vehicle Accidents** *(Kim, Matsuoka, Schnyder, Freedman, Ursano)* Psychiatric Morbidity Following a Motor Vehicle Accident and its Impact on Health-Related Quality of Life Quality of Life Following Accidental Injury Preventing PTSD by Early Treatment in Road Traffic Accidents and Other Events	**A**	**Clin Res, Assess Dx**	**Monroe Ballroom**	**6**	**67**
Symposium/Panel	**The Relationship Between Killing, Mental Health, and Functional Impairment in Veterans and Police** *(Maguen, McCaslin, Inslicht, Marmar)* The Impact of Killing in Vietnam Veterans Impact of Line-of-Duty Killing/Serious Injury in Urban Police Officers The Impact of Taking Another Life in Operation Iraqi Freedom (OIF) Soldiers Returning From Deployment	**M**	**Mil Emer, Soc Eth**	**Adams Ballroom**	**6**	**67**
Symposium/Panel	**Applying Innovative Technologies in Trauma Research and Clinical Practice** *(Carlson, Woodward, Dalenberg)* Using a Portable, Automated, Electronic Method to Collect Real-Time Data from Trauma Survivors Using Mattress Actigraphy to Investigate Aspects of Sleep in PTSD Using Breathing Biofeedback to Enhance Cognitive Behavioral Treatment of Trauma Survivors	**I**	**Res Meth, Bio Med**	**Salons 7 – 9**	**3**	**68**
Symposium/Panel	**Interventions Following Terrorism from 3 Months to 5 Years Post-Event** *(Cloitre, Nacasch, Clark, Duffy, Foa)* Community-Based Cognitive Therapy for PTSD Following the Omagh and London Bombs in the UK Treatment of PTSD Linked to Terrorism and Other Civil Conflict in Northern Ireland: A Randomized Controlled Trial Prolonged Exposure Therapy (PE) Among Patients Suffering From PTSD Due to Terror Attacks in Israel – An Open Study Resolving PTSD and Rebuilding Psychological and Social Resources for 9/11-Exposed Individuals	**M**	**Disaster, Clin Res**	**Grand Ballroom**	**4**	**69**
Paper Presentations	Recent Developments in PTSD Research			**Salon 2**	**3**	**70**
	A Prospective Examination of Posttraumatic Stress Symptoms From Motor Vehicle Accident to Recovery *(Fischer)*	**I**	**Res Meth, Assess Dx**			**70**
	Correlates of Acute and Chronic Posttraumatic Stress Disorder *(Bolton)*	**M**	**Assess Dx, Clin Res**			**70**
	The Impact of Trauma Exposure, Psychiatric Diagnosis, and Resilience on HPA Axis Function *(Weiss)*	**M**	**Bio Med, Cul Div**			**70**
	Resource Loss, Personal Values and Distress Among Native Israelis and New Immigrant Terror Victims *(Fass)*	**I**	**Civil Ref, Cul Div**			**70**
Workshop/ Case Presentation	**PTSD Treatment Programs: Developing and Implementing Evidence-Based Practice** *(Phipps, Chard)*	**M**	**Practice, Clin Res**	**Salon 1**	**3**	**71**
Workshop/ Case Presentation	**Burundian Refugee in the U.S.: Mobilizing Protective Resources** *(Weine, Hakizimana, Landgren, Gahungu)*	**M**	**Civil Ref, Cul Div**	**Salon 3**	**3**	**71**
Workshop/ Case Presentation	**A Manualized Group Protocol of Exposure, Cognitive, and Behavioral Treatments for PTSD** *(Castillo, Keane, Montgomery)*	**A**	**Clin Res, Prev EI**	**Salons 4 – 6**	**3**	**71**

Thursday, November 13

12:30 p.m. – 1:45 p.m.	**Student Lunch**	**Red Lacquer Room**	**4**
2:00 p.m. – 3:15 p.m.	**Student Internship and Post-Doctoral Networking Fair**	**Red Lacquer Room**	**4**

Thursday, November 13, 2:00 p.m. – 3:15 p.m.
Concurrent Session 3

		Presentation Level	Keywords	Room	Floor	Page #
Featured	**Trauma and Reparative Justice** *(Danieli, Hirsh, Laperriere, Mones)*	**M**	**Soc Eth, Media Ed**	**Grand Ballroom**	**4**	**72**
Symposium/Panel	**The First Blueprint for International Mass Casualty Intervention: 5 Principles to Guide Intervention and Research** *(Hobfoll, Ursano, Watson, de Jong)*	**M**	**Prev EI, Disaster**	**Wabash Room**	**3**	**72**
Symposium/Panel	**Brief Eclectic Psychotherapy for PTSD: New Evidence** *(Schnyder, Gersons, Wittmann, Nijdam)* Brief Eclectic Psychotherapy for PTSD; An Introduction Posttraumatic Growth and PTSD Symptoms in Response to Brief Eclectic Psychotherapy and EMDR Brief Eclectic Psychotherapy for PTSD – A Randomized Controlled Trial Posttraumatic Growth: A Possible Outcome of Brief Eclectic Psychotherapy?	**A**	**Clin Res, Practice**	**Salons 4 – 6**	**3**	**72**
Symposium/Panel	**Longitudinal Studies Assessing Neurocognitive Functioning in Relation to Trauma** *(Meewisse, Golier, Vasterling, Cardenas-Nicolson)* PTSD Symptoms in the Early and Intermediate Aftermath of a Disaster Predict Long-Term Attentional Deficits Longitudinal Brain Assessment of Cognitive Performance in Holocaust Survivors Neuropsychological Outcomes of the Iraq War: One-Year Follow-Up of Active Duty Soldiers Longitudinal Brain Atrophy and Neurocognition in PTSD	**M**	**Bio Med, Clin Res**	**State Ballroom**	**4**	**73**
Symposium/Panel	**Symptom Clusters, Comorbidities, Provider Detection, and Preference-Weighted Health Status of PTSD** *(Freed, Yeager, Magruder)* Is There a Link Between PTSD Symptom Clusters and Medical and Psychiatric Morbidity? Are PTSD Symptom Patterns Related to Primary Care Provider (PCP) Diagnosis of PTSD? Preference-Weighted Health Status in Veterans With PTSD	**M**	**Practice, Assess Dx**	**Adams Ballroom**	**6**	**74**
Symposium/Panel	**Co-Occurring Partner Violence and Mental Health: Novel Settings for Identification and Treatment** *(Bryant-Davis, Talbot, Chaudron, Cerulli, Krupnick)* Psycho-Social Risk Factors, Intimate Partner Abuse, and African American Women Evidence-Based Depression Treatment in Community Care: IPT for Women With Trauma Histories Exploring the Overlap of Intimate Partner Violence and Perinatal Depression Linking Court-Based Intimate Partner Victims With Mental Health Services: Will They Connect?	**M**	**Clin Res, Assess Dx**	**Salons 7 – 9**	**3**	**74**
Symposium/Panel	**Measuring Fidelity in Treatment Implementation: Validity vs. Practicality** *(Hanson, Saunders, Kolko, Berliner)* Fidelity in Treatment Implementation: Overview Assessing Treatment Fidelity in Trauma-Focused Treatment With Children Fidelity in the Field: Adherence to AF-CBT in an Effectiveness Trial	**M**	**Clin Res, Practice**	**Monroe Ballroom**	**6**	**75**

Thursday, November 13, 2:00 p.m. – 3:15 p.m.
Concurrent Session 3 (continued)

		Presentation Level	Keywords	Room	Floor	Page #
Paper Presentations	Novel Interventions for PTSD			Salon 1	3	76
	PTSD: Is the Internet of Any Use? *(Herbert, Brunet)*	M	Media Ed, Res Meth			76
	Development and Pilot-Test of a Group Intervention for Traumatized Homeless Women *(Rayburn, Gilbert)*	I	Clin Res, Commun			76
	Treating PTSD With a Time-Limited Psychodynamic Approach: Manual Development and Efficacy Data *(Shafran)*	M	Clin Res, Child			76
	Effect of a Motivation Intervention on Treatment Engagement Process Variables Among PTSD Veterans *(Murphy)*	M	Clin Res, Mil Emer			77
Paper Presentations	PTSD and Conflict-Affected Children			Crystal Room	3	77
	School-Based Intervention for War-Affected Children: Randomized Trials in Burundi and Indonesia *(Tol)*	M	Clin Res, Civil Ref			77
	Use of Subjective Measures in the Assessment of Terrorism Among Children in Southern Darfur *(Morogs)*	M	Child, Assess Dx			77
Workshop/ Case Presentation	**State by State Partnership in Support of Returning Combat Veterans and Their Families** *(Straits-Troster, Kudler, Goodale, Oliver)*	M	Commun, Prev EI	Salon 3	3	77
Workshop/ Case Presentation	**Creating a Trauma-Informed Child Welfare System: The Child Welfare Trauma Training Toolkit** *(Ko, Sprague)*	M	Media Ed, Child	Salon 2	3	78

Thursday, November 13, 3:30 p.m. – 4:45 p.m.
Concurrent Session 4

Master Clinician	**Cognitive Therapy for Posttraumatic Stress Disorder** *(Clark)*	M	Practice, Clin Res	Monroe Ballroom	6	78
Media Presentation	**SOLDIERS OF CONSCIENCE: Award-Winning Documentary About Killing in War (PBS Broadcast – Oct. 2008)** *(Weimberg, Slattery, Ryan, Maguen)*	I	Media Ed	Crystal Room	3	78
Symposium/Panel	**Not to Forget Culture—Studies on the Development and Maintenance of PTSD** *(Maercker, Norris, Hinton, de Jong, Hobfoll)*	M	Cul Div, Res Meth	State Ballroom	4	79
	PTSD in the Vietnamese Community Following Hurricane Katrina					
	The Culturally Sensitive Assessment of Trauma-Related Disorder Among Refugees: A Cambodian Example					
	Can Culture and Values Co-construct PTSD? A Study in China and Germany					
	The Debate on PTSD as a Universal Valid Diagnosis Versus a Culture-Bound 'Western' Construct					
Symposium/Panel	**The Clinical Effectiveness of Empirically-Supported Treatments for PTSD** *(Kehle, Chard, Galovski, Schnurr, Hembree)*	M	Clin Res, Practice	Salon 1	3	80
	The Effectiveness of Cognitive Processing Therapy in Multiple Settings					
	Establishing the Effectiveness of Cognitive Processing Therapy (CPT)					
	A Systematic Review of the Effectiveness of Exposure-Based Treatments for PTSD					
	Impact of Random Assignment to Treatment Condition on Expectancy of Outcome and Treatment Retention					

Thursday, November 13, 3:30 p.m. – 4:45 p.m.
Concurrent Session 4 (continued)

		Presentation Level	Keywords	Room	Floor	Page #
Symposium/Panel	**PTSD and Intimate Partner Relationships: Correlates and Clinical Implications** *(Schumm, Taft, Meis, Sautter, Keane)* Intimate Partner and General Aggression Perpetration Among Veterans in a PTSD Clinic PTSD Symptoms, Substance Abuse, and Partner Violence Among Female Substance Abusers Traumatic Experiences and Symptoms of PTSD in a Clinical Sample of Intimate Partner Violent Men The Development of a Couple-Based Intervention to Improve the Management of Anxiety and Emotion in OEF/OIF Veterans With PTSD and Their Spouses	M	Practice, Clin Res	Salons 7 – 9	3	81
Symposium/Panel	**Spreading Best Practices to Communities: Results From Two Statewide Implementations of TF-CBT** *(Lang, Fitzgerald, Franks, Hanson, Markiewicz)* The Connecticut TF-CBT Learning Collaborative Project BEST	M	Clin Res, Comm	Salon 3	3	82
Symposium/Panel	**Imagery Rehearsal for Nightmares: RCT With Vietnam War Veterans, Pilot With OIF Returnees and Beyond** *(Cook, Harb, Ross, Gamble)* Imagery Rehearsal: Evidence, Description and Examples Imagery Rehearsal for Posttraumatic Nightmares in Vietnam War Veterans: A Randomized Controlled Trial Open Pilot Study of Imagery Rehearsal With OIF Returnees and Design of Bi-Site RCT in OEF/OIF Veterans	M	Clin Res, Practice	Adams Ballroom	6	82
Symposium/Panel	**Mental Health Lessons Learned From the American Red Cross Response to the World Trade Center Attack** *(Tramontin, Halpern, Ryan, Avila, White-Tapp)* Introduction to Humanitarian Relief Work Initial Impact Disaster Mental Health Interventions, September 2001 Through June 2002 Putting 9/11 in Perspective — What is Different Now?	I	Disaster, Prev EI	Wabash Room	3	83
Workshop/ Case Presentation	**A Case Study Using the Trauma Assessment Pathway (TAP) Model** *(Killen-Harvey, Conradi)*	A	Practice, Child	Salon 2	3	83
Workshop/ Case Presentation	**Assessing and Enhancing Treatment Engagement in OEF/OIF Veterans** *(Murphy, Stanton)*	M	Mil Emer, Practice	Salons 4 – 6	3	84

Thursday, November 13

5:00 p.m. – 6:00 p.m.	**Poster Session 1 With Authors Present/Cash Bar**	Exhibition Hall	4	
6:15 p.m. – 7:00 p.m.	**ISTSS Business Meeting**	Adams Ballroom	6	
7:15 p.m. – 8:00 p.m.	**Awards Ceremony**	Adams Ballroom	6	
8:00 p.m. – 11:00 p.m.	**Welcome Reception**	Grand Ballroom	4	
9:30 p.m. – 11:00 p.m.	**Dancing**	State Ballroom	4	

Friday, November 14

		Room	Floor
7:00 a.m. – 8:00 a.m.	Coffee and Tea	Exhibition Hall	4
7:00 a.m. – 5:00 p.m.	Registration Open	Grand Ballroom	4
7:00 a.m. – 6:00 p.m.	Bookstore/Exhibits Open	Exhibition Hall	4

Friday, November 14, 8:00 a.m. – 9:15 a.m.
Concurrent Session 5

		Presentation Level	Keywords	Room	Floor	Page #
DSM-V	Introduction to the Anxiety Disorders			Grand Ballroom	4	84
	An Update on the *DSM-V* Development Process *(Phillips, Friedman)*	M	Assess Dx, Practice			84
	Where Does PTSD Fit in the Overall Classification System?					
	Should PTSD Continue to be Classified as an Anxiety Disorder? *(Resick)*	A	Assess Dx, Res Meth			84
	Is PTSD a Stress-Induced Fear Circuitry Disorder? *(Shin)*	M	Bio Med, Assess Dx			84
	Should PTSD be Included in a New Cluster of Post-Event Psychiatric Disorders? *(Keane)*	A	Assess Dx, Practice			85
Master Clinician	**Integrating Human Rights Principles Into Clinical Practice: Working With Refugees and Asylum Seekers** *(Steel)*	M	Civil Ref, Cul Div	Crystal Room	3	85
Media Presentation	**Profiles of Resilience, Coping, and Adaptation: Survivors Tell Their Stories** *(Hollander-Goldfein, Perlo)*	M	Media Ed	Salons 4 – 6	3	85
Symposium/Panel	**The European Network for Traumatic Stress: Evidence Based Practice for Disaster Victims in Europe** *(Witteveen, Nordanger, Ajdukovic,Bisson)*	I	Disaster, Cul Div	Salon 3	3	85
	Mapping Existing Services for Post-Disaster Psychosocial Care Across Europe: Quantitative Findings					
	Post-Disaster Structures and Resources in Romania and Norway					
	Services and Psychosocial Care After Disasters—Qualitative Findings from South East Europe					
	Psychosocial Model of Care Following Disasters: Achieving Consensus Using the Delphi Method					
Symposium/Panel	**Addressing Barriers to Service Utilization for Returning Iraq and Afghanistan Veterans and Families** *(Scotti, Polusny, Unger,Whealin, Lyons)*	M	Mil Emer, Clin Res	Adams Ballroom	6	86
	WV Veterans Returning From Iraq and Afghanistan: Impact on Personal and Family Functioning					
	Mental Health Risk and Resilience in OIF Deployment National Guard Soldiers: Prospective Predictors					
	Developing Outreach, Education, Prevention and Mental Health Services for Returning OEF/OIF Veterans					
	Cultural and Logistical Barriers to Mental Health Care of OIF/OEF Veterans in the Pacific Islands					
Symposium/Panel	**The North Sea Oil Rig Disaster of 1980 Revisited and a Preventive Rock Slide Study** *(Hoyer Holgersen, Boe, Holen, Rod)*	M	Disaster, Res Meth	Salons 7 – 9	3	87
	Predicting Posttraumatic Growth in an Aging Disaster Population					
	Reactivation of Posttraumatic Stress in Disaster Survivors					
	Peritraumatic Death Threat as a Long-Term Predictor					
	Living With Rock Slide Risk—People's Communication Needs and Perception of Risk					

Friday, November 14, 8:00 a.m. – 9:15 a.m.
Concurrent Session 5 (continued)

		Presentation Level	Keywords	Room	Floor	Page #
Symposium/Panel	**Children Living With Fear: The Effects of War, Terrorism, and Domestic Violence** *(Weatherill, Nyaronga, Kamboukos, Dekel, Ross)* Relationships Between Parental Deployment and Child Adjustment in Military Families Multiple Traumatization, Psychopathology and Resilience in Children Exposed to the 9/11 World Trade Center Attacks Emotional Reactions of Israeli Adolescents Following the Second Lebanon War Developmental Differences in Self-Reported Domestic Violence Exposure and Posttraumatic Stress Disorder in Children and Adolescents	**M**	**Child, Civil Ref**	**State Ballroom**	**4**	**88**
Symposium/Panel	**Acute Medical Interventions for Prevention and Treatment of PTSD: Considerations and New Findings** *(Mouthaan, Visser, Gabert, van Stegeren, Zatzick)* Acute Medication and Trauma-Related Psychopathology in Level I Trauma Center Patients Salivary Cortisol and PTSD Symptom Clusters in Rescue Workers Early Secondary Interventions With Hydrocortisone for In-Hospital Trauma Patients Interaction of Noradrenaline and Cortisol on Brain Activation and Emotional Memory	**M**	**Bio Med, Clin Res**	**Salon 1**	**3**	**89**
Symposium/Panel	**PTSD Clinical Complexity Associated With Co-Occurring Major Depression** *(Zoellner, Bedard, Echiverri, Stines Doane, Aguirre McLaughlin)* Who Seeks Treatment? The Complexity of PTSD in Clinical Trials Physical Scars? Co-Occurring PTSD and MDD, Childhood Trauma, Cardiovascular Activity and Physical Health Sudden Gains During Exposure Therapy for PTSD: Does Co-Occurring Depression Matter? Alliance Patterns in Exposure Therapy for PTSD and PTSD Co-Occurring with Depression	**I**	**Clin Res, Practice**	**Monroe Ballroom**	**6**	**90**
Symposium/Panel	**Implementation of TF-CBT: A Multi-Cultural Look at Multi-Level Influences From Policy to Fidelity** *(Berliner, Murray, Jensen, Saunders)* Implementing TF-CBT in the USA Implementing TF-CBT in Zambia Implementing TF-CBT in Norway	**I**	**Clin Res, Child**	**Wabash Room**	**3**	**91**
	A Comparison of African-American and Caucasian Women in Cognitive Behavioral Treatments for PTSD *(Lester)*	**I**	**Cul Div, Clin Res**			**91**
Workshop/ Case Presentation	**Understanding and Treating Anger in Canadian Forces Members and Veterans With Military-Related PTSD** *(Smith, Richardson)*	**M**	**Practice, Mil Emer**	**Salon 2**	**3**	**91**

Friday, November 14, 9:30 a.m. – 6:00 p.m.
Poster Session 2 Open

Exhibition Hall **4**

Friday, November 14, 9:30 a.m. – 10:45 a.m.
Concurrent Session 6

		Presentation Level	Keywords	Room	Floor	Page #
DSM-V	Why Are Some People More Likely to Get PTSD Than Others?			Grand Ballroom	4	92
	Child and Adolescent Traumatic Stress and PTSD: A Developmental Perspective *(Pynoos)*	M	Assess Dx, Child			92
	Gene-Environment Interaction in Posttraumatic Stress Disorder *(Koenen)*	I	Bio Med, Res Meth			92
	Epigenetics and PTSD: A New Frontier in PTSD Risk and Implications for *DSM-V* *(Yehuda)*	M	Bio Med, Assess Dx			92
	Diagnostic Overlap Between PTSD and MDE in Two American Indian Populations: Implications for *DSM-V* *(Beals, Belcourt-Dittloff)*	M	Assess Dx, Cul Div			92
Media Presentation	**All the Way Home—A Documentary Film** *(Buchen)*	I	Media Ed	Salons 4 – 6	3	93
Symposium/Panel	**Complex Trauma in Children & Adolescents: Treatment Needs and Methods** *(Fletcher, Stolbach, Cloitre, DeRosa, Saxe)*	M	Child, Practice	State Ballroom	4	93
	Is Trauma-Focused Narrative Work an Essential Component of Complex Trauma-Focused Treatment?					
	How Can Treatment Identify, Address and Resolve the Adverse Impact of Trauma on Development Among Traumatized Adolescents?					
	What are the Essential Components for Complex Trauma Treatment With Adolescents?					
	What Processes Need to be Considered in Order for Effective Treatments to Take Hold in the 'Real World'?					
Symposium/Panel	**PTSD and the Khmer Rouge Trials in Cambodia** *(Sonis)*	M	Civil Ref, Commun	Crystal Room	3	94
	Posttraumatic Stress and Refugee Status Decision-Making *(Herlihy, Cleveland, Steel)*	M	Civil Ref, Soc Ethic			94
	Asylum Seekers With Posttraumatic Symptoms Facing the Canadian Refugee Determination Process					
	Refugee Decision-Making and the Tortured Asylum Seeker – Outcomes Amongst Recently Arrived Asylum Seekers in Australia					
	Assumptions Underlying Refugee Status Decisions in the UK – A Qualitative Analysis					
Symposium/Panel	**Disaster Mental Health and Older Adults: Implications for Research, Practice, and Policy** *(Cook, Brown, Elmore)*	I	Disaster, Soc Ethic	Salon 3	3	95
	State of the Evidence: Older Adults' Disaster Mental Health Responses					
	Meeting the Mental Health Needs of Elders After Disasters					
	The Role of Public Policy in Addressing the Needs of Older Adults During Disasters					
Symposium/Panel	**First Responders: Recovery From Terrorist Attacks and Other Critical Incidents** *(Halpern, Neylan, Wild, Gurevich, Baum)*	M	Mil Emer, Prev EI	Wabash Room	3	95
	Trauma in Paramedics: A Survey of Key Factors Affecting Psychological Outcomes					
	Paramedics Exposed to the London Bombings of 7 July: A Prospective Study Investigating Cognitive and Neuropsychological Predictors of PTSD					
	Emergency Medical Dispatchers Rally Resources to Combat Stress					
	Building Personal and Professional Resilience					

Friday, November 14, 9:30 a.m. – 10:45 a.m. Concurrent Session 6 (continued)		Presentation Level	Keywords	Room	Floor	Page #
Symposium/Panel	**Studying the Phenomenology of PTSD in Groups and Individuals: What Can it Tell Us?** *(Lauterbach, Palmieri, Mason, Carlson)* Factor Structure of the Impact of Event Scale-Revised: Stability Across Cultures and Time PTSD Symptom Structure is Reasonably Invariant Across Comorbid Depression Status Confirmatory Factor Analysis and Invariance of the Davidson Trauma Scale in a Longitudinal Sample of Burn Patients Individual Differences in the Phenomenology of PTSD Over Time	M	Assess Dx, Res Meth	Monroe Ballroom	6	96
Paper Presentations	PTSD After Mass Shootings			Salons 7 – 9	3	97
	A Prospective Examination of Risk Factors for PTSD Following a Mass Shooting *(Hattula)*	I	Disaster, Prev EI			97
	The Mental Health and Attitudes of People With a Personal Connection to the 9/11 Terrorist Attacks *(Jones)*	I	Disaster, Practice			97
	PTSD and Risk Factors in Lower Manhattan Residents 2-3 Years After 9/11 *(DiGrande)*	M	Disaster, Assex Dx			98
	The Relationship Between Depression and Posttraumatic Stress Disorder Following a Mass Trauma *(Weiner)*	M	Disaster, Assess Dx			98
Workshop/ Case Presentation	**Assessing Readjustment From OIF/OEF Using the Post-Deployment Readjustment Inventory** *(Katz, McCarthy, Williams)*	M	Assess Dx, Mil Emer	Salon 2	3	98
Workshop/ Case Presentation	**A New Past-Focused Model for PTSD and Substance Abuse** *(Najavits)*	M	Practice, Clin Res	Salon 1	3	98

Friday, November 14, 11:00 a.m. – 12:15 p.m. Concurrent Session 7						
DSM-V	Examining the Construct Validity of PTSD and ASD			Grand Ballroom	4	99
	Factor Structure of PTSD: Implications for *DSM-V* *(Palmieri)*	M	Assess Dx, Res Meth			99
	PTSD and the Internalizing/Externalizing Model of Comorbidity *(Miller)*	A	Assess Dx, Bio Med			99
	Acute Stress Disorder in *DSM-V* *(Bryant)*	M	Assess Dx, Prev EI			99
Media Presentation	**Leave None Behind** *(Grenier, Bailey)*	M		Salons 4 – 6	3	99
Symposium/Panel	**A City-Wide School-Based Model for Building Resiliency in the Wake of War and Terror** *(Pat-Horenczyk, Baum, Brom, Benbenishty, Schiff)* A Conceptual and Methodological Framework for City-Wide School-Based Monitoring in Communities Exposed to Prolonged and Severe Violence Teachers Resilience and Needs in the Wake of War Do Children Know When They Are Distressed? Employing Students' Self Reports of Emotional Status and Need for Help A School-Based City-Wide Intervention Model for Building Resilience in the Shadow of War and Terror	M	Child, Commun	State Ballroom	4	100

Friday, November 14, 11:00 a.m. – 12:15 p.m.
Concurrent Session 7 (continued)

		Presentation Level	Keywords	Room	Floor	Page #
Symposium/Panel	**Current Perspectives on the Role of Cognitive Factors in the Maintenance and Treatment of PTSD** *(Ehring, Wild, Stines Doane, Zoellner, Kleim)* First Responders at the London Bombings of 7 July: Predictors of Recovery From PTSD Characteristics of Explicit and Implicit Trauma Memory in PTSD Trauma-Related Cognitions in Critical Sessions: Does Cognitive Change Precipitate Symptom Reduction? Cognitive Change Mediates Symptom Reduction in Cognitive Therapy for PTSD	A	Clin Res, Assess Dx	Monroe Ballroom	6	100
Symposium/Panel	**Early Diagnosis and Intervention in Mass Casualty Events** *(Kutz, Dekel, Schreiber)* Acute Stress Reaction (ASR): Methods of Assessment and Prediction of Acute Stress Disorder The Effect of a Single Session of EMDR on Intrusive Distress in Acute Stress Syndromes Intervention for Memory Structuring and Meaning Acquisition With Survivors of Terror When Post-Trauma is Also a Pre-Trauma: Working With Mental Health Teams Under Ongoing Rocket Attacks	M	Prev EI, Assess Dx	Adams Ballroom	6	101
Symposium/Panel	**Improving Disaster Mental Health Care Through Evaluation: Program Outcomes, and Treatment Referrals** *(Norris, Rosen, Hamblen)* Service Characteristics and Outcomes: Lessons From a Cross-Site Evaluation of Crisis Counseling After Hurricanes Katrina, Rita and Wilma Factors Predicting Referrals to Other Crisis Counseling, Disaster Relief, and Psychological Services After Hurricane Katrina Evaluation of Cognitive Behavioral Therapy for Post-Disaster Distress (CBT-PD) for Hurricane Katrina Survivors	M	Disaster, Clin Res	Salons 7 – 9	3	102
	EMDR HAP Training in Pakistan in the Aftermath of the 2005 Earthquake and the 'War on Terror' *(Farrell)*	I	Disaster, Media Ed			103
Paper Presentations	Refugee Mental Health			Crystal Room	3	103
	Trauma, Mental Health, and Anger in Timor Leste *(Steel)*	M	Civil Ref, Cul Div			103
	Terror and Its Aftermath: Impact of Persecution and Refugee Camp Experiences on Arab Immigrant Women *(Norris, Aroian)*	I	Cul Div, Civil Ref			103
	Culture, Trauma, and Psychiatric Impairment Amongst Vietnamese Living in Vietnam and Australia *(Steel)*	M	Civil Ref, Cul Div			104
	The Relationship Between Post-Migration Problems and Refugee Mental Health *(Carswell)*	M	Practice, Soc Eth			104
Paper Presentations	First Responders			Wabash Room	3	104
	Atypical Work Hours and PTSD Among Police Officers *(Violanti)*	I	Mil Emer, Soc Eth			104
	The Psychological Impact of the 7th July London Bombings Upon London Ambulance Service Personnel *(Greenberg)*	M	Mil Emer, Disaster			104
	9/11 Responders and High Rates of Posttraumatic Stress Disorder *(Barrett)*	A	Assess Dx, Clin Res			105
	Manhattan Clinicians' Resilience and Professional Satisfaction in the Aftermath of the 9/11 Disaster *(Tosone)*	M	Practice, Disaster			105

Friday, November 14, 11:00 a.m. – 12:15 p.m.
Concurrent Session 7 (continued)

		Presentation Level	Keywords	Room	Floor	Page #
Workshop/ Case Presentation	**Supported Employment Versus Standard Vocational Rehabilitation for Veterans With PTSD** *(Davis, Dreding, Toscano, Riley)*	**I**	**Pratice, Clin Res**	**Salon 1**	**3**	**105**
Workshop/ Case Presentation	**Conducting Ethical and Responsible Trauma-Focused Research With Special Populations** *(Nelson Goff, Schwerdtfeger)*	**I**	**Res Meth, Soc Eth**	**Salon 2**	**3**	**105**
Workshop/ Case Presentation	**The Challenges of Conducting and Analyzing Small to Moderate Sized Longitudinal Studies** *(Sunday, Labruna, Kaplan)*	**M**	**Res Meth, Assess Dx**	**Salon 3**	**3**	**106**

Friday, November 14, 12:45 p.m. – 1:45 p.m.
Special Interest Group Meetings

SIG	**Diversity and Cultural Competence**	**Crystal Room**	**3**	
SIG	**Human Rights and Social Policy**	**Salon 1**	**3**	
SIG	**Intergenerational Transmission of Trauma and Resilience**	**Salon 2**	**3**	
SIG	**Media**	**Salon 3**	**3**	
SIG	**Millitary**	**Salons 4 – 6**	**3**	
SIG	**Research Methodology**	**Salons 7 – 9**	**3**	
SIG	**Spirituality**	**Monroe Ballroom**	**6**	
SIG	**Terrorism and Bioterrorism-Related Trauma**	**Wabash Room**	**3**	
SIG	**Trauma Assessment and Diagnosis**	**State Ballroom**	**4**	

Friday, November 14, 2:00 p.m. – 3:15 p.m.
Concurrent Session 8

DSM-V	Should There Be a Complex Trauma Diagnosis in *DSM-V*?			**Grand Ballroom**	**4**	**106**
	Developmental Trauma Disorder: Towards a Rational Diagnosis of the Sequelae of Chronic Childhood Abuse and Neglect *(van der Kolk)*	**M**	**Assess Dx, Res Meth**			**106**
	What is Complex About Complex PTSD and Does It Matter for Treatment? *(Cloitre)*	**M**	**Assess Dx Clin Res**			**106**
	Dissociation and the Complex Trauma Reactions *(Vermetten)*	**M**	**Assess Dx, Practice**			**107**
Master Clinician	**Eye Movement Desensitization and Reprocessing: Clinical Case Presentation** *(Solomon)*	**I**	**Practice, Clin Res**	**Salons 4 – 6**	**3**	**107**
Symposium/Panel	**Innovations in Experimental Psychopathology Research** *(Malta, Kleim, Rothbaum, Pitman)*	**M**	**Res Meth, Clin Res**	**Monroe Ballroom**	**6**	**107**
	Using Novel Technologies to Develop and Test Laboratory Models of PTSD					
	Cognitively Oriented Experimental Approaches to Modeling PTSD Symptoms					
	Clinical Translational Early Intervention Research Based on Animals Models of PTSD					
	Deficient Extinction Retention in Posttraumatic Stress Disorder					
Symposium/Panel	**Interpersonal Victimization: Predictors, Consequences, and Clinical Intervention** *(Iverson, Weatherill, Dutton, Kilpatrick)*	**M**	**Practice, Clin Res**	**Wabash Room**	**3**	**108**
	Military Sexual Harassment and Sex-Role Egalitarianism Among Marine Recruits					
	Long-Term PTSD Trajectories and Physical Health for Women Exposed to Intimate Partner Violence					
	Violent Victimization, PTSD Symptom Clusters					
	Treatment Response of Battered Women With PTSD to Cognitive Processing Therapy					

Friday, November 14, 2:00 p.m. – 3:15 p.m.

Concurrent Session 8 (continued)

		Presentation Level	Keywords	Room	Floor	Page #
Symposium/Panel	**Mental Health in Children Following Hurricanes Katrina and Rita** *(Jaycox, Walker, Cohen, Mannarino, Jones)* Hurricane and Trauma Exposure and Symptoms 15 Months Post-Hurricane A Stepped-Care Service Delivery Approach to Meeting Mental Health Needs of Children Post-Disaster Comparison of Two Approaches to Bringing Evidence-Based Care to School Children Post-Disaster	**M**	**Child, Disaster**	**State Ballroom**	**4**	**109**
Paper Presentations	Post-Deployment Adjustment in Veterans			**Adams Ballroom**	**6**	**110**
	Treating Veterans and Their Families: Are Practitioners Utilizing Evidence–Supported Practice? *(Halpern)*	**M**	**Mil Emer, Clin Res**			**110**
	Peer Support for Canadian Injured Soldiers and Their Families: The Results of a Needs Analysis *(Cargnello)*	**M**	**Commun, Mil Emer**			**110**
	The Impact of Childhood Abuse and Combat-Related Trauma on Soldiers' Post-Deployment Adjustment *(Mishkind)*	**M**	**Mil Emer, Practice**			**110**
	A Novel Self-Management Intervention for PTSD Related to Military Sexual Trauma: Early RCT Findings *(Strauss)*	**M**	**Clin Res, Mil Emer**			**111**
Paper Presentations	Trauma Treatment in Conflict Zones			**Crystal Room**	**3**	**111**
	Community-Based Sociotherapy in Rwanda; Its Effects on Mental Health *(Verduin)*	**M**	**Clin Res, Civil Ref**			**111**
	Community-Based Sociotherapy in Rwanda; Its Effects on Social Functioning and Social Capital *(Scholte)*	**M**	**Clin Res, Civil Ref**			**111**
	Traumas and Transformational Coping Mechanisms Among Japanese American Hiroshima/ Nagasaki Survivors *(Ikeno)*	**I**	**Disaster, Cul Div**			**111**
	Posttraumatic Growth Following the Disengagement: A Longitudinal Study of the Gaza Settlers *(Hall)*	**I**	**Civil Ref, Disaster**			**112**
Paper Presentations	Emotion, Sensitivity and Regulation			**Salon 1**	**3**	**112**
	Emotion Regulation Difficulties in Survivors of Type I and Type II Traumas *(Ehring)*	**M**	**Clin Res, Assess Dx**			**112**
	Attention Bias Among Interpersonal Violence Survivors: A Comparison of Stroop and Dot Probe Paradigms *(Scher)*	**M**	**Assess Dx, Clin Res**			**112**
	Does the Modified Stroop Effect (MSE) Exist in PTSD? *(Kimble)*	**I**	**Assess Dx, Res Meth**			**112**
	The Relation Between PTSD and Sensitivity to Emotional Context *(Milanak)*	**I**	**Assess Dx, Clin Res**			**113**
Paper Presentations	Sexual Assault			**Salon 3**	**3**	**113**
	Are Different Types and Tactics of Sexual Assault Associated with More Deleterious Outcomes? *(Zayed)*	**I**	**Res Meth, Clin Res**			**113**
	Posttraumatic Symptoms Related to Unwanted Sexual Experiences Among College Students *(Flack)*	**I**	**Clin Res, Soc Eth**			**113**
	Sexual Abuse and Help Seeking Patterns in Turkey *(Yuksel)*	**A**	**Practice, Cul Div**			**113**
	Is Sexual Assault Disclosure Therapeutic? Comparing Lab Versus Field Study Results *(Ullman)*	**I**	**Clin Res, Soc Eth**			**114**

Friday, November 14, 2:00 p.m. – 3:15 p.m. Concurrent Session 8 (continued)		Presentation Level	Keywords	Room	Floor	Page #
Paper Presentations	PTSD After Mass Shootings and Disasters			Salons 7 – 9	3	114
	Anxiety Sensitivity and PTSD Symptom Severity Following the NIU Shootings on February 14, 2008 *(Stephenson)*	M	Disaster, Prev EI			114
	Experiential Avoidance as a Risk Factor for PTSD Symptoms Following a Mass Shooting *(Orcutt)*	I	Disaster, Prev EI			114
	Impact of Exposure to Trauma on PTSD Symptomatology in Swedish Tsunami Survivors *(Berg-Johannesson)*	M	Disaster, Clin Res			114
	A Community Psychology Program for Meeting the Needs of the Elderly Following the Kashmir Earthquake *(Dodge)*	A	Disaster, Commun			115
Workshop/ Case Presentation	**The Core Concepts, Skills, and Components Curriculum: Increasing Trauma Expertise in Practitioners** *(Layne, Gewirtz, Ghosh Ippen, Abramovitz, Stuber)*	M	Media Ed, Child	Salon 2	3	115

Friday, November 14, 3:30 p.m. – 4:45 p.m. Concurrent Session 9						
DSM-V	Should the Trauma Criteria be Retained or Revised?			Grand Ballroom	4	116
	The Criterion A Problem: On the Past, Present, and Future of the Stressor Criterion for PTSD *(Weathers)*	M	Assess Dx, Res Meth			116
	Defining Criterion A: Philosophical and Empirical Controversies *(Kilpatrick)*	M	Assess Dx, Res Meth			116
	Traumatic Events Should Meet Either Criterion A1 or A2 Not Both *(Brewin)*	I	Assess Dx, Bio Med			116
	Do We Need Criterion A2? *(Schnurr)*	M	Assess Dx, Res Meth			116
Symposium/Panel	**Constructing Terror: Traumatization of Detained Terror Suspects** *(Aronson, Conroy, Smith, Fletcher, Olson)* The Torturer Speaks: A Journalist's Interviews With Former Torturers Guantánamo and its Aftermath: A Study of Detainees Released From U.S. Custody at Guantánamo Bay Ethical Issues Concerning the Role of Psychologists in the Interrogation of Detained Prisoners	I	Soc Eth, Mil Emer	Crystal Room	3	117
Symposium/Panel	**Current Age and Assessment Issues for Different Types of Trauma in Children and Adolescents** *(Nader, Cohen, Levendosky, Fletcher)* An Introduction to the Differences in Youth and Adult Trauma and a Review of Findings for Adolescents Assessment of Trauma in School-Aged Children Current Findings on PTSD for Children Under 8: Domestic Violence as a Case Example A Measure to Assess Children's Reactions to Chronic Interpersonal Stressors	I	Child, Assess Dx	State Ballroom	4	117
Symposium/Panel	**Applying Mindfulness-Based Interventions for Trauma Across Diverse Populations** *(La Bash, Follette, Dutton, Niles, Elbert)* Mindfulness-Based Trauma Interventions for Intimate Partner Violence Evaluation of a Mindfulness Telehealth Intervention for Veterans With PTSD Treatment of Psychological Trauma in Children after War in North-Eastern Sri Lanka: A Randomized Controlled Trial Comparing NET vs Mindfulness Meditation/Relaxation The Role of Mindfulness in a Randomized Clinical Trial of Affect Regulation and Social Problem Solving Psychotherapies for Low-Income Mothers With PTSD	I	Clin Res, Cul Div	Monroe Ballroom	6	118

Friday, November 14, 3:30 p.m. – 4:45 p.m.
Concurrent Session 9 (continued)

		Presentation Level	Keywords	Room	Floor	Page #
Symposium/Panel	**Risk and Resilience Following Mass Trauma: The Virginia Tech Campus Shootings** *(Littleton, Bye, Axsom)* Examining Post-Shooting Distress From a Conservation of Resources Framework Cumulative Effects of Multiple Traumas on Quality of Life: Benevolence Beliefs as a Potential Mediator Social Support Following the Virginia Tech Shootings	I	Disaster, Soc Eth	Salons 7 – 9	3	110
Paper Presentations	Biological Issues in Veterans			Adams Ballroom	6	120
	Headaches in Veterans Returning From Iraq/Afghanistan: Relation to Trauma and Combat-Related Injury *(Afari, Madra)*	M	Mil Emer, Clin Res			120
	Thinner Prefrontal Cortex in Veterans With Posttraumatic Stress Disorder (Geuze)	M	Bio Med, Res Meth			120
	Resting Brain Metabolic Activity in Identical Twins Discordant for Combat Exposure *(Shin, Pitman)*	A	Bio Med, Res Meth			120
	Global and Regional Cortical Volumes in Combat-Related Posttraumatic Stress Disorder *(Woodward)*	A	Bio Med, Assess Dx			121
Paper Presentations	Treatment Issues in Combat-Related Stress			Salon 1	3	121
	Acupuncture for Posttraumatic Stress Disorder: A Randomized Trial in a Military Population *(Engel)*	M	Clin Res, Mil Emer			121
	Pilot Study of a Mindfulness-Based Cognitive Therapy for Combat Veterans Seeking Treatment for PTSD *(King)*	M	Mil Emer, Clin Res			121
	Relationship Between Traumatic Events and Suicide Attempts in Canadian Military Personnel *(Belik)*	I	Mil Emer, Clin Res			121
	Posttraumatic Stress Disorder and Health Related Quality of Life in Canadian Peacekeeping Veterans *(Richardson)*	M	Mil Emer, Assess Dx			122
Paper Presentations	Basic Research in PTSD			Salon 3	3	122
	Effects of Repeated Stress on Cannabinoid Receptor Type 1 mRNA Expression in Rat Brain *(Carlton)*	M	Bio Med, Res Meth			122
	Stress-Induced Regional and Sex Differences in Adrenergic Receptor mRNA in Rat Brain *(Carlton)*	M	Bio Med, Res Meth			122
	Serotonin Transporter Gene Modulates Neural Systems for Working Memory in PTSD *(Morey)*	M	Bio Med, Assess Dx			123
	Low BDNF and Childhood Physical Neglect Impacting Verbal Memory in Depression *(Grassi-Oliveira)*	A	Bio Med, Assess Dx			123
Workshop/ Case Presentation	**Teaching Trauma** *(Kimble, Flack, Elhai, Davis, Krause)*	I	Media Ed, Soc Eth	Salon 2	3	123
Workshop/ Case Presentation	**Utilization of EMDR With Traumatic Bereavement** *(Solomon, Rando)*	M	Practice, Disaster	Salons 4 – 6	3	124
Workshop/ Case Presentation	**Immigrants and Domestic Violence (DV): Adjusting the Clinical Lens** *(Woollett)*	M	Cul Div, Practice	Wabash Room	3	124

Friday, November 14

5:00 p.m. – 6:00 p.m.	**Poster Session 2 With Authors Present/Cash Bar**	**Exhibition Hall**	**4**	
5:00 p.m. – 6:00 p.m.	**Book Signing**	**Exhibition Hall**	**4**	
8:00 p.m. – 9:30 p.m.	**Play Reading: Jonathan Shay's *Achilles In Vietnam***	**Grand Ballroom**	**4**	

Saturday, November 15		Room	Floor
7:00 a.m. – 8:00 a.m.	Coffee and Tea	Exhibition Hall	4
7:00 a.m. – 2:00 p.m.	Bookstore Open/Exhibits	Exhibition Hall	4
7:00 a.m. – 3:30 p.m.	Registration Open	Grand Ballroom Foyer	4

Saturday, November 15, 8:00 a.m. – 9:15 a.m. Concurrent Session 10		Presentation Level	Keywords	Room	Floor	Page #
Featured	The Biology of PTSD			Grand Ballroom	4	124
	Making Relevant Animal Models for PSTD: Looking for Phenotypic Variation Rather Than Typical Response to Stress *(Yehuda)*	M	Res Med, Bio Med			124
	Animal Models in PTSD: Their Contribution to Pharmacotherapy *(Zohar)*	M	Bio Med, Prev EI			124
Master Clinician	**Treating Complex Trauma in Older Adolescents and Adults: The Self-Trauma Model** *(Briere)*	M	Practice, Clin Res	State Ballroom	4	125
Symposium/Panel	**Narrative Exposure Therapy as a Treatment for Traumatized War Victims: The Evidence** *(Neuner, Elbert, Martina, Ertl)* Treatment of Posttraumatic Stress Disorder by Trained Lay Counselors in an African Refugee Settlement Narrative Exposure Therapy Versus Group Interpersonal Psychotherapy – An RCT With Orphans of the Rwandan Genocide The Efficacy of KIDNET (Narrative Exposure Therapy for Children) in the Treatment of Traumatized Refugee Children: 6- and 12-Months Follow up of a Randomized Controlled Trial Narrative Exposure Therapy: A Disseminable, Community-Based Treatment Approach for Former Child Soldiers	M	Civil Ref, Clin Res	Crystal Room	3	125
Symposium/Panel	**Afterdeployment.org: A Self-Guided Education and Skills Building Web Site** *(Gahm, Ciulla, Whealin, Johnson, Ruzek)*	M	Prev EI, Mil Emer	Monroe Ballroom	6	126
Symposium/Panel	**Addressing Child Trauma in Pediatric Medical Settings** *(Kassam-Adams, Alister Groves, Marsa, Landau Fleisher, Kohser)* Developing Training for Pediatric Providers About Young Children and Trauma Preventing and Responding to Traumatic Stress: Web-Based Tools for Parents and Health Care Providers Traumatic Stress Consultation: Establishing Trauma-Focused Services in the PICU Implementing and Evaluating a Stepped Preventive Intervention for Hospitalized Injured Children	M	Child, Prev EI	Salons 7 – 9	3	126
Symposium/Panel	**Smoking, Nicotine, and Trauma** *(Acheson, Wilson, Kirby, McDonald, Gulliver)* Smoking Among U.S. Veterans Deployed to Iraq/Afghanistan: Health-Related and Demographic Correlates Relapse and Craving During a Smoking Cessation Quit Attempt Among Smokers With and Without PTSD Smoking in Help-Seeking Veterans With PTSD Returning From Iraq and Afghanistan Cigarette Smoking Modulates Mood and Attention in Posttraumatic Stress Disorder	I	Clin Res, Mil Emer	Wabash Room	3	127
Paper Presentations	Resilience in the Face of War			Adams Ballroom	6	128
	Predictors of Resiliency and Posttraumatic Stress Disorder Following Traumatic Injury *(deRoon-Cassini)*	M	Bio Med, Prev EI			128
	Measuring Resilience in OIF/OEF Veterans *(Mavissakalian)*	M	Clin Res, Assess Dx			128
	The Relationship Between Resilience and PTSD: A Test of the BASIC-PH Model in the Context of War *(Farchi)*	M	Prev EI, Clin Res			128
	Deployment Risk Among Women Veterans: Traumatic Experiences and Mental Health Outcomes *(Wooten)*	I	Mil Emer, Practice			128

Saturday, November 15, 8:00 a.m. – 9:15 a.m.		Presentation Level	Keywords	Room	Floor	Page #
Concurrent Session 10 (continued)						
Paper Presentations	Child Maltreatment and PTSD			**Salon 1**	**3**	**129**
	Posttraumatic Stress Symptom Trajectory in Children With Reported Family Violence *(Nugent)*	**M**	**Child, Res Meth**			**129**
	Symptom Development Following Child Maltreatment: Understanding the Role of Attributions *(Risk)*	**M**	**Child, Assess Dx**			**129**
	Emotion Dysregulation and Trauma-Related Internalizing Symptoms After Child Psychological Abuse *(Coates)*	**I**	**Assess Dx, Child**			**130**
	Co-Occurrence of Community Violence and Child Maltreatment: Assessing Risk for PTSD *(Aisenberg)*	**I**	**Child, Cul Div**			**130**
Paper Presentations	Predictors and Treatment Issues in Children			**Salon 3**	**3**	**130**
	Fear Activation and Habituation During Imaginal Exposure in Youth Suffering From PTSD *(Rachamim)*	**M**	**Clin Res, Child**			**130**
	A Web-Based Early Intervention for Children and Their Parents Following Unintentional Trauma *(Cox)*	**I**	**Prev EI, Child**			**130**
	Exploring the Relationships Among Dissociation, Victimization, and Juvenile Sexual Offending *(Leibowitz)*	**M**	**Child, Assess Dx**			**131**
Paper Presentations	Sleep and Trauma			**Salons 4 – 6**	**3**	**131**
	Cognitive Behavioral Social Rhythm Therapy for Veterans With PTSD, Depression, and Insomnia *(Haynes)*	**M**	**Clin Res, Mil Emer**			**131**
	The Role of Fear of Sleep and Rumination in the Sleep Disturbance of Patients With PTSD *(Zayfert)*	**M**	**Clin Res, Practice**			**131**
	Sleep in Healthy Adults With History of Childhood Trauma Exposure *(Neylan)*	**A**	**Bio Med, Assess Dx**			**131**
	Overcoming Treatment Resistant PTSD Nightmares With an Endocannabinoid Receptor Agonist *(Fraser)*	**M**	**Practice, Clin Res**			**132**
Workshop/ Case Presentation	**Managing Deployment Stress: The Vermont VA/National Guard Program** *(Pomerantz, Gajda, Slone)*	**M**	**Prev EI, Commun**	**Salon 2**	**3**	**132**

Saturday, November 15, 9:30 a.m. – 10:45 a.m.						
Concurrent Session 11						
Symposium/Panel	**The Genetics of Posttraumatic Stress Disorder: What Do We Know So Far?** *(Brunet, Thakur, Koenen, Lee, Joober)* Association Between Posttraumatic Stress Disorder and the 5-HTTLPR Polymorphism Association Between RGS2 and Generalized Anxiety Disorder in an Epidemiologic Sample of Hurricane-Exposed Adults Psychosocial and Genetic Susceptibility to Posttraumatic Stress Disorder	**M**	**Bio Med, Res Meth**	**Grand Ballroom**	**4**	**132**
Symposium/Panel	**Converging Evidence for Developmental Trauma Disorder: Empirical Support From Large Databases** *(Stolbach, Putnam, Kisiel, Pynoos, van der Kolk)* Childhood Antecedents of Clinical Complexity Symptoms of Developmental Trauma Disorder in a Sample of Youth Entering the Child Welfare System in Illinois Trauma Exposure, Adverse Experiences, and Diverse Symptom Profiles in a National Sample of Traumatized Children	**M**	**Child, Assess Dx**	**State Ballroom**	**4**	**133**

Saturday, November 15, 9:30 a.m. – 10:45 a.m.
Concurrent Session 11

		Presentation Level	Keywords	Room	Floor	Page #
Symposium/Panel	**How to Overcome Military Members' Mental Health Stigma and Barriers to Care** *(Slone, Friedman, Southwick, Stecker, Washam)* Barriers to Mental Health Care Among OEF/OIF Veterans Presenting at VA Predicting Treatment Seeking in OIF National Guard Soldiers VA's Reserve Components PDHRA Partnership With DoD – Overcoming Barriers to Care Among the Reserve & National Guard	**M**	**Mil Emer, Clin Res**	**Adams Ballroom**	**6**	**134**
Symposium/Panel	**Predicting and Treating Posttraumatic Stress in Injured Children** *(Nixon, McKinnon, Le Brocque, Kassam-Adams)* The Influence of Memory Processes on the Development and Maintenance of Posttraumatic Stress Symptoms in Children The Course of Posttraumatic Stress Disorder: An Exploration of Recovery Trajectories of Children and Their Parents Following Accidental Injury Evaluating Information and Psycho-Education as Secondary Prevention After Pediatric Injury A Comparison of Cognitive Behavior Therapy Versus Cognitive Therapy for Childhood PTSD	**M**	**Child, Clin Res**	**Salons 7 – 9**	**3**	**134**
Symposium/Panel	**Mindfulness, Meditation, and CBT: Similarities and Differences** *(Waelde, Gillis, Batten, Walser)* Possible Mechanisms of Mindfulness and Meditation as PTSD Interventions Mindfulness as a "Complementary" Treatment for Posttraumatic Stress Disorder The Role of Mindful Awareness in Facilitating Committed Action Use of Mindfulness in Treating PTSD	**M**	**Clin Res, Practice**	**Wabsh Room**	**3**	**135**
Paper Presentations	Cross-Cultural Assessment and Field Research			**Crystal Room**	**3**	**136**
	Multilingual Computerized Diagnostics in Traumatized Refugees: Validity and Acceptance of MultiCASI *(Mueller)*	**I**	**Assess Dx, Clin Res**			**136**
	HIV-Related Stigma and Concerns in Relation to Distress Among Malawi Women *(Khaylis)*	**I**	**Cul Div, Soc Eth**			**136**
	Spirit Possession as an Idiom of Distress, Coping With the Aftermath of Terror and Trauma in Uganda *(Van Duijl)*	**I**	**Cul Div, Assess Dx**			**137**
	Readiness to Reconcile and Mental Health in Traumatized Refugees *(Knaevelsrud)*	**I**	**Civil Ref, Assess Dx**			**137**
Paper Presentations	Research Issues and PTSD Factor Structure			**Monroe Ballroom**	**6**	**137**
	Trauma Victim: Yes or No? Why It May be Difficult to Answer Traumatic Event Screening Questionnaires *(Thoresen)*	**M**	**Assess Dx, Clin Res**			**137**
	The Myth of Subject Burden: Participants' Reactions to Research Assessment *(Iverson)*	**I**	**Assess Dx, Clin Res**			**137**
	A Four-Factor Structure of the Posttraumatic Diagnostic Scale (PDS): The Addition of Dysphoria *(Helpman)*	**I**	**Assess Dx, Cul Div**			**138**
	Confirmatory Factor Analysis of PTSD in Female Survivors of Sexual and/or Physical Abuse or Assault *(Hetzel-Riggin)*	**M**	**Assess, Dx, Res Meth**			**138**
Workshop/ Case Presentation	**Family Informed Trauma Treatment Model** *(Kiser, Thompson, Connors)*	**M**	**Practice, Soc Eth**	**Salon 1**	**3**	**138**
Workshop/ Case Presentation	**How to Succeed in Publishing as a Student** *(Legerski, Geffner, Schnurr, Taft, La Bash)*	**I**	**Media Ed, Res Meth**	**Salon 2**	**3**	**138**
Workshop/ Case Presentation	**Psychological Effects of Long-Term Deployment on Children of Military Presentation Personnel** *(Findeis, Findeis)*	**M**	**Practice, Child**	**Salon 3**	**3**	**139**
Workshop/ Case Presentation	**Treating Trauma-Related Sleep Problems: An Evidenced-Based Cognitive Behavioral Approach** *(Zayfert, DeViva)*	**I**	**Practice, Clin Res**	**Salons 4 – 6**	**3**	**139**

Saturday, November 15, 9:30 a.m. – 6:00 p.m. — **Room** **Floor**
Poster Session 3 Open — **Exhibition Hall** **4**

Saturday, November 15, 11:00 a.m. – 12:15 p.m.		**Presentation Level**	**Keywords**	**Room**	**Floor**	**Page #**
Concurrent Session 12						
Media Presentation	**News Media and Trauma—Candid Views From Australian Journalists** *(Millar, McMahon, Newman, Spratt)*	**I**		**Salons 4 – 6**	**3**	**140**
Symposium/Panel	**Perspectives on Internship, Post-Doc and Residency: Getting the Most Out of Your Experience** *(Averill, Batten, Sedlar, Frank, Moore)*	**I**	**Media Ed, Practice**	**Salon 2**	**3**	**140**
Symposium/Panel	**Optimizing Survey and Experimental Methods in PTSD Prevention Trials** *(Zatzick, Shalev, O'Donnell, Galea)* Survey and Experimental Methods in PTSD Prevention Trials: The Jerusalem Trauma Outreach and Prevention Study (J-TOPS) Early Psychological Intervention Following Traumatic Injury: An Effectiveness Trial Elucidating a Reciprocal Relationship Between Effect Size and Intervention Reach in Early PTSD Prevention Trials	**M**	**Clin Res, Res Meth**	**Monroe Ballroom**	**6**	**140**
Symposium/Panel	**Recent Developments in Mild Traumatic Brain Injury** *(Iverson, Kenardy, Hoge, Bryant)* Methodology Matters: Reducing Risk for Misdiagnosing the Persistent Post-Concussion Syndrome Predictors of Health Functioning at 12-Months Post-Injury in Children With Traumatic Brain Injury Mild Traumatic Brain Injury and Post-Concussive Symptoms Among Veterans of the Wars in Iraq and Afghanistan: What Would Sir Bradford Hill Have to Say? Mild Traumatic Brain Injury and Psychiatric Disorder	**M**	**Assess Dx, Practice**	**Adams Ballroom**	**6**	**141**
Symposium/Panel	**ISTSS at the UN and the 60th Anniversary of the Universal Declaration of Human Rights** *(Danieli, Carll, Braak, Turner)* Do Rights Reach Victim/Survivors? Media/ICT, Human Rights, and Social Change ISTSS Collaboration Work With UN Bodies, NGOs, and Committees	**I**	**Cul Div, Soc Eth**	**Salons 7 –9**	**3**	**142**
Symposium/Panel	**Transformation of Trauma Through Media** *(McFarlane, Pynoos, Weisaeth)* Transformation of Trauma Through Art & Literature Historical Chronology of Danger, Trauma & Terror Edvard Munch – Pioneer Psychotraumatologist?	**M**	**Disaster, Soc Eth**	**Wabash Room**	**3**	**142**
Symposium/Panel	**Trauma and Self: Culture, Identity, and Cognitive Predictors of Depressive and PTSD Symptoms** *(DePrince, Klest, Hebestreit, Kaysen, Pineda)* Trauma, Personality and Demographic Predictors of Depression Examining Links Between Violence Exposure, Depression, and Executive Function An Examination of Trauma Exposure, PTSD Symptoms and Substance Use in Sexual Minority College Students Appraisals of Self and Others in Relation to Posttraumatic Distress in Young Adults	**M**	**Clin Res, Practice**	**State Ballroom**	**4**	**143**
Symposium/Panel	**Posttraumatic Stress, Maternal Health and Pregnancy Outcomes** *(Charvat, Yehuda, Morland)* Trauma in the Womb: Biological Mechanisms for Transmission of Maternal Trauma and PTSD to Offspring A Sequential Examination of Posttraumatic Stress Across the Gestational Period Including Postpartum Trauma and Prenatal and Perinatal Care: The Relationship Between Postraumatic Stress and Women's Health Care Choices During the Prenatal and Perinatal Time Periods	**M**	**Clin Res, Bio Med**	**Grand Ballroom**	**4**	**143**
	HPA Axis Evidence of Transgenerational Effects of Maternal Early Life Trauma in 6-Month-Old Infants *(Brand)*	**A**	**Child, Bio Med**			**144**

Saturday, November 15, 11:00 a.m. – 12:15 p.m.
Concurrent Session 12 (continued)

		Presentation Level	Keywords	Room	Floor	Page #
Symposium/Panel	**Impact of Catastrophic Events on First Responders and Children** *(Brymer, Osofsky, Osawa, Kato, Osofsky)* Impact of Hurricane Katrina on First Responders The Long-Term Impact of the Kobe Earthquake and a Subsequent Traumatic Accident on Firefighters Impact of Hurricane Katrina on Children The Psychological Impact of a School Shooting on High School Students	**M**	**Disaster, Child**	**Salon 1**	**3**	**144**
Workshop/Case	**Companion Recovery Model Reduces the Effects of Trauma for Male and Female Child Soldiers in Liberia** *(Gregory, Embry)*	**I**	**Clin Res, Civil Ref**	**Salon 3**	**3**	**145**
Workshop/Case	**Best Laid Plans: Challenges and Benefits of Conducting Research With Refugees and Displaced Persons** *(Osterman, de Jong)*	**M**	**Civil Ref, Res Meth**	**Crystal Room**	**3**	**146**

Saturday, November 15, 12:45 p.m. – 1:45 p.m.
Special Interest Group Meetings

SIG	**Child Trauma**	**Crystal Room**	**3**
SIG	**Complex Trauma**	**Salon 1**	**3**
SIG	**Creative Body and Energy Therapies**	**Salon 2**	**3**
SIG	**Early Interventions**	**Salon 3**	**3**
SIG	**Family Systems Approaches to Trauma**	**Salons 4 – 6**	**3**
SIG	**Internet and Technology**	**Salons 7 – 9**	**3**
SIG	**Primary Care and Trauma**	**Monroe Ballroom**	**6**
SIG	**Psychodynamic Research and Practice**	**Wabash Room**	**3**
SIG	**Traumatic Loss and Complicated Grief**	**State Ballroom**	**4**

Saturday, November 15, 2:00 p.m. – 3:15 p.m.
Concurrent Session 13

Featured	Soldiers at War: The Perspective of Two Journalists			**Adams Ballroom**	**6**	
	Addressing PTSD in Combat Troops Returning From Iraq and Afghanistan *(Kennedy)*	**I**	**Mil Emer, Media Ed**			**146**
	How Iraq Veterans are Fighting the Next War Here in America *(McKelvey)*	**I**	**Soc Ethic, Mil Emer**			**146**
Master Clinician	**Treating Acute Stress Disorder** *(Bryant)*	**M**	**Prev EI, Clin Res**	**Monroe Ballroom**	**6**	**146**
Symposium/Panel	**Resiliency in the Face of Terrorism and Mass Casualty: Keys to Our Understanding of Thriving, Surviving, and Making it to the Next Day** *(Hobfoll, Bonanno, Galea, Shalev)*	**M**	**Disaster, Prev EI**	**Grand Ballroom**	**4**	**147**
Symposium/Panel	**Examining Posttraumatic Growth in Children and Youth: Cross-Cultural Findings** *(Kilmer, Alisic, Hafstad, Taku)* Posttraumatic Growth Among Children Impacted by Hurricane Katrina Posttraumatic Growth in a Dutch Sample of Primary School Children Family Correlates of Posttraumatic Growth in Children and Adolescents Posttraumatic Growth Among Japanese Middle School Students	**I**	**Child, Cul Div**	**Salon 1**	**3**	**147**

Saturday, November 15, 2:00 p.m. – 3:15 p.m.
Concurrent Session 13 (continued)

		Presentation Level	Keywords	Room	Floor	Page #
Symposium/Panel	**Psychosocial Effects of Terrorist Threat and Close Protection in Politicians** *(Gersons, Nijdam, Friedman, McFarlane)* Preventing Traumatic Distress for Politicians Under Terrorist Threat and Close Protection Terrorist Threat and Close Protection: A Model for Coping Responses in Politicians Optimizing Resilience and Personal Growth in Close Protection Advising Politicians Regarding Their Professional Practice and Social Environment	M	Prev EI, Soc Eth	Crystal Room	3	148
Symposium/Panel	**Revictimization: Examining Cognitive, Emotion, and Social Risk Factors** *(DePrince, Gobin, Chu, Dietrich)* Revictimization in Young Women: A Test of the Interpersonal Schema Hypothesis Trust and Revictimization Among Betrayal Trauma Survivors Physiological Activation and Trauma Appraisals: Potential Mechanisms of Risk Detection and Revictimization PTSD and Associated Features in Revictimization of Men and Women	I	Clin Res, Practice	State Ballroom	4	148
Symposium/Panel	**From Evidence to Practice: Knowledge Synthesis, Dissemination and Transfer for Better PTSD Treatment** *(Creamer, Lewis, O'Donnell, Ruzek)* Knowledge Synthesis Knowledge Dissemination to Diverse Audiences Knowledge Transfer for Best Practice and Better Outcomes	I	Clin Res, Media Ed	Wabash Room	3	149
Paper Presentations	PTSD in Displaced Populations			Salon 2	3	150
	Distress, Well-Being and War: Qualitative Analysis of Civilian Interviews From North-East Sri Lanka *(Jayawickreme)*	M	Civil Ref, Assess Dx			150
	PTSD, Depression, and Psychosis in Somali Refugees *(Kroll)*	M	Civil Ref, Assess Dx			150
	The Psychological Impact of the Kidnapping in Colombia: An Approach From the Media *(Manrique Cortés)*	I	Media Ed, Civil Ref			150
Paper Presentations	Predictors and Correlates in PTSD			Salons 7 – 9	3	151
	Stress Hormones and Peritraumatic Dissociation as Causal Pathways Between Trauma History and PTSD *(Irish)*	M	Bio Med, Assess Dx			151
	PTSD and Weight Gain: Results From the National Comorbidity Study – Replication (NCS-R) *(de Vries)*	I	Bio Med, Soc Eth			151
	The Relationship Between Personality and Personality Disorder in a PTSD Sample *(Wolf)*	M	Clin Res, Assess Dx			151
Workshop/ Case Presentation	**Complex Trauma, Complex Needs: Building Capacity to Address Trauma and DV in Public Systems** *(Warshaw, Pease, Blumenfeld)*	M	Commun, Soc Eth	Salons 4 – 6	3	151
Workshop/ Case Presentation	**Implementing Trauma-Informed Care in Residential Mental Health Settings for Youth** *(Hummer, Dollard)*	M	Clin Res, Child	Salon 3	3	152

Saturday, November 15, 3:30 p.m. – 4:45 p.m.
Concurrent Session 14

		Presentation Level	Keywords	Room	Floor	Page #
Symposium/Panel	**Low Income and Ethnic Minority Women: Multiple Trauma and Effects, Culturally Sensitive Treatments** *(Triffleman, Kaltman, Campbell, Krupnick, Green)* The Relationship Between Trauma and Depression The Health Impact of Lifetime Trauma and Violence in a Diverse Sample of Female Veterans IPT for Low-Income Women With PTSD After Interpersonal Trauma Discussion: Accessible, Innovative, Appropriate Interventions for Low Income Women	I	Cul Div, Clin Res	Salon 2	3	152
Symposium/Panel	**Policy Issues in Immediate and Intermediate Response to Disaster and Terror** *(Seyle, Watson, Lee, Ligenza)* Policy and Psychological First Aid Bridging the Policy Gap: Partnerships Between Universities and NGOs as a Method for Addressing Needs How to Best Mitigate the Impact of Mass Trauma: Recommendations From an Assembly of Experts	M	Soc Eth, Disaster	Crystal Room	3	153
Symposium/Panel	**Torture and Mental Health: What is Torture, and How Should Professional Organizations Respond?** *(Scott, Berthold, Briere)*	I	Soc Eth, Civil Ref	Adams Ballroom	6	153
Symposium/Panel	**Delayed Onset PTSD: New Research on an Old Controversy** *(Andrews, Brewin, Engdahl, Creamer)* Risk Factors for Delayed Onset PTSD in UK Servicemen The Development of Delayed Onset PTSD in UK Servicemen The Onset of Post-War PTSD; Contrasts in Trauma Severity and Study Design A Prospective Study of Delayed PTSD and Depression Following Traumatic Injury	M	Assess Dx, Res Meth	Monroe Ballroom	6	154
Symposium/Panel	**Mental Health of War-Affected Youth in Two Conflicts: The Role of the Family, Community and Classroom** *(Borisova, Betancourt, Tol)* The Role of the Family in the Reintegration and Adjustment of Former Child Soldiers The Impact of Stigma on the Reintegration and Adjustment of Former Child Soldiers Cluster Randomized Trial on a School-Based Intervention in War-Affected Northern Sri Lanka	M	Child, Civil Ref	Salon 1	3	155
Symposium/Panel	**The Long-Term Consequences of Terrorism: Findings From Clinical and Population-Based Studies** *(Silver, Neria, Holman, Gil-Rivas, Poulin)* The Long-Term Sequelae of Terrorism: PTSD Trajectories in the First Five Years After the 9/11 Attacks Early Predictors of Long-Term Health Status and Utilization Following the 9/11 Terrorist Attacks The Social Context of Coping With Ongoing Threat and Well-Being Following the 9/11 Terrorist Attacks Societal and Political Outcomes of 9/11: 9/11-Related Distress and Support for Aggressive U.S. Policies	M	Disaster, Soc Eth	Salons 4 – 6	3	155
Symposium/Panel	**When Violent Behavior is the Etiological Stressor: Psychotherapy as Future Violence Prevention** *(Lipke, MacNair)* Clinical Psychology: Guilt and Subsequent Destructive Behavior Social Psychology: Post-Trauma Symptoms and Causation of Violence	I	Practice, Soc Eth	Salons 7 – 9	3	156
	Combining CBT With a Social Support Intervention for Treating PTSD: Results of a Randomized Study *(Guay)*	M	Clin Res, Practice			157
	The Role of PTSD in Violence, Arrest, and Treatment Engagement Among People With SMI *(Cusack)*	M	Clin Res, Soc Eth			157

Saturday, November 15, 3:30 p.m. – 4:45 p.m. **Concurrent Session 14** (continued)		Presentation Level	Keywords	Room	Floor	Page #
Paper Presentations	Complex PTSD in Children			Salon 3	3	157
	Childhood Emotional Abuse as a Predictor of Adverse Outcomes: Results From a Meta-Analysis *(Taylor)*	I	Pre EI, Assess Dx			
	Posttraumatic Stress Symptoms in Children and Adolescents Receiving Child Welfare Services *(Kolko)*	M	Child, Clin Res			157
	Childhood Trauma, Poverty, and Adult Victimization: An Application of Multilevel Modeling *(Klest)*	M	Pre EI, Res Meth			158
	Terror and Trauma for Homeless and Prostituted Street Youth: How Can Societal Response be Improved? *(Williams)*	M	Child, Commun			158
Paper Presentations	Journalism and Vicarious Traumatization			Wabash Room	3	158
	Secondary Trauma in Journalism: A Critical Ethnographic Study *(Keats)*	M	Media Ed, Prev EI			158
	Case Study of Vicarious Traumatization of Field Researchers of Trauma *(Ajdukovic)*	M	Clin Res, Prev EI			158
	A Comparative Analysis of Clinical and Administrative Occupational Stress in VA Health Care Workers *(Newell)*	M	Prev EI, Res Meth			159
	The Lingering Effects of Trauma: Bedouin Wives and Mothers of Men Serving in Israel's Defense Forces *(Caspi)*	M	Cul Div, Assess Dx			159

Saturday, November 15

5:00 p.m. – 6:00 p.m.	**Poster Session 3 With Authors Present/Closing Reception**	**Exhibition Hall**	**4**	
6:00 p.m.	**24th ISTSS Annual Meeting Adjourns**			
6:30 p.m. – 7:30 p.m.	**Reception for VA and DoD Employees Hosted by the National Center for PTSD**	**Red Lacquer Room**	**4**	

Pre-Meeting Institutes
Wednesday, November 12

To register for an ISTSS Pre-Meeting Institute(s) held on November 12, indicate which session(s) you wish to attend on the registration form located on page 49, and include the proper payment with the registration form. Only those holding tickets for specific sessions will be admitted. Discounts are available if you register for more than one half-day Pre-Meeting Institute.

Note: Presenters are bold and Discussants are italicized. Technical Level is italicized and Participant Alert is bold.

Pre-Meeting Institutes
Wednesday, November 12
Full Day
8:30 a.m. – Noon and 1:30 p.m. – 5:00 p.m.

1 Trauma-Focused CBT for Children: Intermediate Level

(Abstract #194072)

Pre-Meeting Institute (Child, Practice) **Salon 1, 3rd Floor**

Technical Level: Advanced

Cohen, Judith, MD[1]; Mannarino, Anthony, PhD[1]
[1]Allegheny General Hospital, Pittsburgh, Pennsylvania, USA

Children experience terror (extreme fear) in response to many traumatic events. Children may express terror through their behavior, emotions, thoughts and/or bodies. Developmental level, family, culture, context and individual factors also influence this expression. When children's terror is unaddressed, their developmental trajectory can dramatically change in unhealthy ways. It is critically important to provide effective treatment to children who have extreme trauma-related fear before this occurs. This PMI provides therapists with intermediate level training in an evidence-based treatment, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for children's Posttraumatic Stress Disorder, depression, shame, behavior problems and other trauma-associated symptoms. It is strongly recommended that prior to attending this PMI participants complete the online training course TF-CBTWeb, available at www.musc.edu/tfcbt. The PMI will be an accelerated and practical training for child therapists in implementing the core TF-CBT components, which are summarized by the acronym PRACTICE : Psychoeducation, Parenting skills, Relaxation, Affective modulation, Cognitive coping, Trauma narrative and cognitive processing of traumatic experiences, Conjoint child-parent sessions, In vivo mastery of trauma reminders, and Enhancing safey and future developmental trajectory. The training will include extensive case examples and role play practice and will provide opportunities for participants to ask two of the TF-CBT treatment developers questions about their treatment cases.

2 Acceptance and Commitment Therapy: Bringing Values to Life Following Trauma

(Abstract #196192)

Pre-Meeting Institute (Practice, Mil Emer) **Salons 4-6, 3rd Floor**

Technical Level: Intermediate.

Walser, Robyn, PhD[1]; Westrup, Darrah, PhD, BEE[2]
[1]International Society for Traumatic Stress Studies, Menlo Park, California, USA
[2]VA Palo Alto Health Care System, Menlo Park, California, USA

Many individuals who suffer with post traumatic stress following acts of terror, war, disaster and violence struggle to regain their pre-trauma lives. Once held personal values are often lost to disbelief and pain. They are also lost to the efforts and desire to avoid traumatic memories, painful feelings and unwanted thoughts. This loss, plus the avoidance strategies themselves, can have a powerful negative impact on individuals diagnosed with PTSD and other trauma related disorders. Acceptance and Commitment Therapy (ACT) is an intervention that targets avoidance by addressing problematic control strategies; and by promoting acceptance of internal experience through practices of willingness and being present in the current moment. Additionally, ACT explicitly explores valued living and works with clients to regain lost values by engaging in behavior change that is consistent with those values. ACT is a structured intervention that applies mindfulness and behavioral techniques, in the treatment of PTSD. We will present the basic theory and application of ACT including covering the six core process: acceptance, present-moment, defusion, self-as-context, values and committed action. We will spend time exploring how these core processes are interwoven to create a compassionate intervention. We will also briefly review empirical support for the intervention.

Participant Alert: This PMI will contain exercises asking participants to engage in experiential exercises. Some of these exercises may focus on their own distress or bring up past upsetting events.

3 Treatment of Prolonged Exposure Therapy (PE)

(Abstract #194834)

Pre-Meeting Institute (Clin Res, Practice) **State Ballroom, 4th Floor**

Technical Level: Advanced

Foa, Edna, PhD[1]; Hembree, Elizabeth, PhD[2]
[1]University of Pennsylvania, Philadelphia, Pennsylvania, USA
[2]Psychiatry, University of Pennsylvania, Philadelphia, Pennsylvania, USA

Clinicians in many settings often find using exposure therapy quite challenging with diverse and complex chronic PTSD clients. Detailed treatment manuals provide clear guidelines and descriptions of procedures, but it is impossible to include all of the nuance and "art" of the therapy. In this advanced workshop, the developers of the highly efficacious "Prolonged Exposure" (PE) treatment program will offer the clinical wisdom that years of experience have taught us about how to modify treatment procedures in order to optimize successful outcome. Flexibility in following the manual and tailoring the treatment to the client´s response to exposure will be emphasized. Recommendations will include how to: 1) build a strong foundation for the therapy; 2) create an effective in-vivo exposure hierarchy; 3) facilitate optimal emotional engagement during imaginal exposure; and 4) modify procedures for clients who over- or underengage in exposure. The procedural modifications will be demonstrated with patients´ videotapes.

This advanced workshop is geared towards participants who have had previous workshop training in Prolonged Exposure Therapy, and preferably have already used exposure therapy with PTSD clients.

Pre-Meeting Institutes
Wednesday, November 12
Half Day
8:30 a.m. – Noon

4 The Interface Between Trauma and OCD: Clinical Issues

(Abstract #193329)

Pre-Meeting Institute (Practice, Assess Dx) **Crystal Room, 3rd Floor**

Technical Level: Intermediate

Winston, Sally, PsyD[1]
[1]*Anxiety and Stress Disorders Institute of Maryland, Towson, Maryland, USA*

Clinicians who treat trauma survivors often encounter patients with persistent and distressing symptoms which are both "obsessive" and "compulsive". Many of these repetitive phenomena seem to both feed and quell overt anxiety. This workshop will address both diagnostic and treatment issues in these patients. Important distinctions must be made between true obsessive-compulsive disorder which can be exacerbated or triggered by traumatic or stressful experience, and those trauma symptoms better described as preoccupation, worry, trauma-based phobia, avoidance of triggers , repetitive re-enactment and various forms of compulsive self-injury. Whether symptoms are functionally autonomous from the trauma material or must be addressed by exposure to the trauma memories will be explored. A framework will be presented for how effective evidence-based treatment of true OCD is conducted. Modifications which may be required in trauma survivors with OCD will be discussed. The role of panic attacks and flashbacks (and the distinctions between them) will be elucidated. Why "safety behaviors" are desired in impulsive patients and discouraged in obsessive-compulsive patients will become clear as this model is presented. Ample clinical examples will be used, and participants are encouraged to share rlevant vignettes of their own.

5 After Terrorist Events: Innovative Disaster Mental Health Systems of Care, Planning—Implementation

(Abstract #196404)

Pre-Meeting Institute (Disaster, Commun) **Salon 2, 3rd Floor**

Technical Level: Intermediate

Gurwitch, Robin, PhD[1]; Schreiber, Merritt, PhD[2]; Perez, Jon, PhD[3]; Coady, Jeff, PsyD[4]; Hughes, Laurel, PsyD[5]; Derrickson, Sean, MSW[6]
[1]*Pediatrics, University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma, USA*
[2]*Center for Public Health and Disasters, UCLA Center for the Health Sciences, Los Angeles, California, USA*
[3]*United States Department of Health and Human Services, Rockville, Maryland, USA*
[4]*HHS, San Francisco, California, USA*
[5]*Addictions and Mental Health, Oregon Department of Human Services, Beaverton, Oregon, USA*
[6]*Multnomah County, Mental Health and Addiction Services, Portland, Oregon, USA*

In the aftermath of terrorist events, it is predicted that upwards of 30-40% of an impacted population will be at risk for mental health disorders and long-term impairment (IOM, 2003, Kessler, et al, 2006). To effectively respond, a disaster mental health systems of care which is interoperable with the other emergency support functions is needed. The model must have a continuum of care (population-based services to individualized evidenced-based treatments) and must address the immediate, short, and long-term mental health needs following terrorist incidents. Typically after disasters/terrorist events, the existing public health infrastructure is compromised. Therefore, the need for systemic level interventions is essential. The "Mercy Model" (Perez, et al, 2006) is a new concept of how to facilitate, organize, and lead systems during disasters. At its core, this model represents a public health leadership approach guiding efforts to create teams and programs for all populations. Allocation of resources is most effective through identification of those in greatest need of mental health care and creating a model of disaster response to achieve mental health parity with other public health disaster initiatives (Pynoos, Schreiber, et al 2005). The proposed model includes a rapid mental health triage and incident management system as increasing evidence suggests that for those at high risk, providing early, brief, interventions may help deflect the trajectory of impairment (Bryant, et al, 2004). PsyStart (Theinkura,et. al, 2006), as such an operational platform, was positively evaluated following the tsunami in Asia and was utilized as part of the TOPOFF4 exercise. Furthermore, as the mental health system may be strapped after terrorist events, residents may be providing services for each other. A new model of Psychological First Aid, Listen, Protect and Connect (www.ready.gov), can fill this need, providing another piece of a disaster mental health systems of care. With any model, special attention must be paid to groups considered high-risk for adverse consequences after an event. Children represent one such group (Guwitch, et al, 2002). From preparedness planning to triage to interventions, children require unique considerations to increase positive outcomes. The workshop will examine an innovative disaster mental health systems of care model from planning through implementation. It will incorporate didactic materials, including findings from natural disasters and terrorist events, video clips, and an experiential terrorist attack exercise. Information from TOPOFF4 will be included to emphasize the components presented in this innovative model for use following acts of terrorism.

Participant Alert: Video and pictures as well as exercise scenario information have content that may create distress in participants.

6 Building Resilience in the Shadow of War and Terror: A School-Based Ecological Intervention Model

(Abstract #195620)

Pre-Meeting Institute (Prev EI, Child) **Salon 3, 3rd Floor**

Technical Level: Intermediate

Baum, Naomi, PhD[1]; Pat-Horenczyk, Ruth, PhD[1]; Brom, Danny, PhD[1]
[1]*Child and Adolescent Clinical Services, The Israel Center for the Treatment of Psychotrauma, Herzog Hospital, Jerusalem, Israel*

We will present our comprehensive ecological model for building resilience in school communities that have been exposed to the trauma of terrorism and war. This model integrates community and clinical approaches to promoting mental health and wellbeing in children. We present a brief overview of the concept of resilience, which is the cornerstone of our work, and lessons learned from school-based intervention programs in varied international settings. A description of our ecological model follows. This model highlights resilience building for teachers and the entire student body, as well as student screening for PTSD and related distress and treatment for affected students. Our workshop will highlight our resilience building workshops for teachers and include a "hands on" simulation of a group session. Guidelines for school-based screening followed by a discussion of different modules of school-based treatment interventions. We will conclude with challenges for implementation and future directions based on our experience.

7 Current Psychopharmacological Treatment of PTSD and the Psychological Underpinnings of the Treatment Alliance

(Abstract #195855)

Pre-Meeting Institute (Practice, Bio Med) **Salons 7-9, 3rd Floor**

Technical Level: Intermediate

Sivak, Joseph, MD[1]
[1]*Private Practice: Joseph J. Sivak MD, PLLC, Duluth, Minnesota, USA*

This training will provide and update the clinician on current psychopharmacology practice standards used to treat chronic PTSD. The focus will be on the outpatient setting, and will primarily consider mainstream allopathic medicine in the western world specifically FDA approved medications including those approved for use in PTSD as well as the many medicaitons used "off-label" for treating patients with PTSD. The second portion will focus on why these medications often have limited utility or partial efficacy and explore the "Nocebo" dynamic. The vantage point will be from a psychosocial perspective, and explore basic psychodynamic issues of medication treatment in the context of an ever increasing, technoloigcal and fast-paced often violent society. Special consideration will be given to the destruction of the family unit, disconnectedness in society, entitlement, victimization, continuous reabandonment and how this is acted out through the metaphor of the medication.

Finally, some consideration of helpful techniques and concepts are discussed for increasing psychopharmacotherapy success, not only for the physician or physician extender providing medical treatment but also for the psychotherapist as part of the dynamic treatment triad. The treamtent triad can be most crucial in medication success as the psychopharm-psychotherapy relationship must be synergistic for the individaul suffering with chronic PTSD.

8 Somatic Intervention: Using the Trauma Resiliency Model (TRM) in the Treatment of Complex Trauma

(Abstract #195865)

Pre-Meeting Institute (Practice, Cul Div) **Monroe Ballroom, 6th Floor**

Technical Level: Intermediate

Leitch, Laurie, PhD[1]**; Miller-Karas, Elaine, MSW**[2]
[1]*Trauma Resource Institute, Santa Fe, New Mexico, USA*
[2]*Trauma Resource Institute, Claremont, California, USA*

This Pre-Meeting Institute (half-day), for intermediate and advanced clinicians, will focus on the application of the Trauma Resiliency Model (TRM), a somatic clinical intervention which is being used in settings that have experienced complex trauma. TRM focuses on the biological basis of trauma and the reflexive, defensive ways the body responds to threat and fear. The approach draws on neuroscience research which shows how trauma affects cortical and subcortical processing of information and the importance of working with defensive responses which were thwarted during the traumatic event.

TRM is a brief, stabilization model inspired by Somatic Experiencing (SE). TRM emphasizes that human responses to threat are primarily instinctive and biological and only secondarily are cognitive and psychological. TRM treatment focuses on identifying the psychophysiological patterns that underlie a wide variety of traumatic responses. The focus of treatment is on unlocking the somatized "stress memories" and movement impulses that remain bound in the body and restoring balance to the nervous system (Levine, 2005) by working with small gradations of traumatic activation alternated with the use of somatic resources. Working with small increments of traumatic material is a key component of TRM treatment as is the development of somatic resources. Together they reduce the likelihood of escalation of arousal, flooding and/or retraumatization and help develop a sense of mastery and self-management over intense somatic states. Cognitions and emotions are addressed in TRM but are not the primary focus of intervention.

Special attention will be paid in the workshop to the relevance of TRM in communally-oriented cultures and with populations that are not insight-oriented. The presentation will emphasize TRM´s skills-based approach and its focus on local capacity-building. Case examples applying TRM will be provided from the presenters' projects in Rwanda with genocide survivors, with anti-female genital mutilation activists in East and West Africa, as well as projects in the US. Discussion will include ways that TRM can complement and be integrated with other clinical models such as CBT. TRM has been found in two studies (one published, one pending publication) to be an effective low-dose treatment.

9 Acceptance and Commitment Therapy for Posttraumatic Anger-Related Problems in Living

(Abstract #196107)

Pre-Meeting Institute (Practice, Mil Emer) **Adams Ballroom, 6th Floor**

Technical Level: Intermediate

Santanello, Andrew, PsyD[1]**; Kelly, Sharon, MSW**[1]
[1]*Trauma Recovery Programs, Veterans Affairs Maryland Health Care System, Baltimore, Maryland, USA*

Anger and aggression are two of the most widely reported and disruptive sequelae of traumatic experiences, especially among veterans (Beckham, Feldman, Kirby, Hertzberg, & Moore, 1997; Jakupcak, et al., 2008). Many anger treatments, such as Stress Inoculation Therapy (SIT), focus on the "management" or control of the various experiences associated with anger such as physiological arousal, hostile attribution bias, increased frequency of automatic thoughts, and aggressive behavior (e.g., Chemtob, Novaco, Hamada, and Gross, 1997). However, the link between trauma, anger, and aggression is not well understood and traditional anger management techniques may serve to reinforce unhelpful change and control agendas. Furthermore, many clients report that effortful control of the experience of anger leads to a viscous cycle of suppression followed by explosive anger episodes. Aiding clients to experience, rather than avoid, their anger and to increase their behavioral repertoire in the context of anger is an alternative strategy. In this workshop, participants will learn an Acceptance and Commitment Therapy (ACT)-based approach to working with posttraumatic anger related problems in living. The presenters will offer an ACT-based conceptualization of posttraumatic anger problems, describe a ACT-based therapeutic strategy for addressing these problems, model specific ACT interventions, and describe a unique ACT-based anger group (Honorably Experiencing Anger and Threat Group, a.k.a. "HEAT" Group) being conducted in the Trauma Recovery Programs of the VA Maryland Health Care System. Participants will have the opportunity to participate in experiential exercises and role-plays to facilitate the acquisition of new skills for working with anger.

Participant Alert: Participants will have the option of participating in experiential exercises (e.g., thinking about a situation in which he or she was angry) designed to illustrate ACT principles.

10 Preventing Psychological & Moral Injury in Military Service: Misconduct Combat Stress Behaviors

(Abstract #196146)

Pre-Meeting Institute (Prev EI, Mil Emer) **Wabash Room, 3rd Floor**

Technical Level: Intermediate

Shay, Jonathan, MD, PhD[1]; Greenberg, Neil, BM[2]; March, Cameron, ADMPT[3]; Nash, William, MD[4]; Stokes, James, MD[5]; Castro, Carl, PhD[6]; Grenier, Lieutenant Colonel Stephane, MSc, CD[7]

[1]Psychiatry, US Department of Veterans Affairs, Newton, Massachusetts, USA
[2]Academic Centre for Defense Mental Health, King's College London, London, United Kingdom
[3]Headquarters Staff of the Commander in Chief Fleet, Royal Marines, Portsmouth, United Kingdom
[4]Headquarters United States Marine Corps, Quantico, Virginia, USA
[5]Medical Evaluation Board, Brooke Army Medical Center, San Antonio, Texas, USA
[6]Division of Psychiatry and Neuroscience, Walter Reed Army Institute of Research, Washington, District of Columbia, USA
[7]Armed Forces Canada, Ottawa, Ontario, Canada

This session will be an informal, unofficial international exchange among military and mental health professionals on prevention and early treatment of psychological and moral injury in military service. No one will speak officially for their services or for their governments. Their remarks are their own. Attendees agree not to publish or circulate attributed quotations, without permission of the person quoted; participation does not imply endorsement of remarks by other presenters. An occupational health framework provides structure: PRIMARY prevention: eliminate war; SECONDARY: redesign culture, policies, and practices to prevent and reduce injury to troops; TERTIARY: early, expert, and far-forward detection, assessment, and treatment of exposures and injuries as they happen, but still within the military institutions. The specific allocation of time among specific levels of prevention, and to specific practices, policies, research overviews and needs for research, will be shaped by the mix of interests brought to the session by attendees. In past years, attendees from all over the world have made enormously valuable contributions, and air time will be provided for attendees who wish to speak at greater length than the usual conference question or comment. The presenters come to learn as well as to teach. Active duty uniformed presenters may be unable to attend if deployed by their forces, but the remaining presenters will be able to conduct the session. This year´s sub-theme is MISCONDUCT COMBAT STRESS BEHAVIORS. All aspects of service member misconduct will be open for consideration: prevention, awareness, cultural and social process dimensions, as a disastrous complication of psychological injury, measurement issues, military leadership, personnel policy, and training dimensions.

Pre-Meeting Institutes
Wednesday, November 12
Half Day
1:30 p.m. – 5:00 p.m.

11 Skills for Psychological Recovery
(Abstract #196225)

Pre-Meeting Institute (Disater, Prev EI) **Crystal Room, 3rd Floor**

Technical Level: Introductory

Watson, Patricia, PhD[1]; Ruzek, Josef, PhD[2]; Vernberg, Eric, PhD[3]; Layne, Christopher, PhD[4]; Berkowitz, Steven, PhD[5]; Jacobs, Anne, PhD[6]
[1]Dartmouth College, White River Junction, Vermont, USA
[2]National Center for PTSD, Palo Alto, California, USA
[3]University of Kansas, Lawrence, Kansas, USA
[4]National Child Traumatic Stress Network, Los Angeles, California, USA
[5]Yale University, New Haven, Connecticut, USA
[6]Psychology, University of Kansas, Lawrence, Kansas, USA

This PMI will offer a practical training of the Skills for Psychological Recovery Field Guide, developed by the National Child Traumatic Stress Network and the National Center for PTSD. Skills for Psychological Recovery (SPR) is an evidence-informed modular approach to help children, adolescents, adults, and families in the weeks and months after disasters and terrorism, after the period where Psychological First Aid is utilized. Skills for Psychological Recovery is a skills-training model designed to accelerate recovery and increase self-efficacy, rather than a mental health model. The PMI will include instruction on six core empirically-derived skill sets that have been shown to help with a variety of post-trauma issues The skill sets are meant to be used in a flexiible, pragmatic manner, based on based on information gathered about ongoing needs and priorities. The interventions include such actions as Information Gathering and Prioritizing Assistance, Building Problem-Solving Skills, Promoting Positive Activities, Managing Reactions to Stress and Reminders, Promoting Helpful Thinking, Written Processing for PTSD/Complicated Grief, and Identifying and Maintaining Healthy Connections. Each action has been used in a number of empirically supported protocols for post-trauma intervention. This workshop will offer in-depth review and examples of each intervention, with video examples, case scenarios, role play, and practice.

12 Group Applications of Cognitive Processing Therapy
(Abstract #196534)

Pre-Meeting Institute (Practice, Clin Res) **Salon 2, 3rd Floor**

Technical Level: Intermediate

Chard, Kathleen, PhD[1]; Rodgers, Carie, PhD[2]
[1]PTSD Division, Cincinnati VA Medical Center, Cincinnati, Ohio, USA
[2]Military Sexual Trauma & Women's PTSD Program, VA San Diego Health Care System, San Diego, California, USA

Cognitive Processing Therapy (CPT) has been shown to be an effective treatment of PTSD for civilian and veteran males and females with various trauma histories. Although often used as an individual therapy, CPT has been found to be an effective group or combined group and individual therapy modality. This workshop will provide training in the use of Cognitive Processing Therapy in various group formats, including combinations with individual therapy. The presenters will conduct a brief review of the utility of group CPT, including data supporting its use in treating PTSD and related symptoms. A session by session overview of the 12 session CPT model will be reviewed including a discussion of all practice assignments and worksheets. Videotape will be used to demonstrate techniques and the audience will be asked to practice exercises over the course of the training. The presenters will make note of ways in which the group session structure differs from individual therapy. Issues regarding pre-treatment assessment, readiness for group, dealing with difficult patients, and after care will be discussed. Finally ways that CPT can be adapted to various settings will be offered including the benefits and drawbacks of the group format.

Participant Alert: There may be a brief discussion of traumatic events that lead to PTSD as part of an explanation of treatment interventions.

13 The Warrior as Patient: Engaging, Assessing and Treating the Returning Veteran
(Abstract #196337)

Pre-Meeting Institute (Mil Emer, Practice) **Salon 3, 3rd Floor**

Technical Level: Introductory

Scurfield, Raymond, DSW[1]; Platoni, Kathy, PsyD[2]; Rasmussen, Cynthia, RN, MSN[3]; Lighthall, Alison, RN, MSN[4]
[1]School of Social Work, University of Southern Mississippi, Long Beach, Mississippi, USA
[2]U.S. Army Reserve (Gulf & Iraq War veteran), Centerville, Ohio, USA
[3]United States Government, North Branch, Minnesota, USA
[4]Hand2Hand CONTACT, Winnetka, Illinois, USA

Combat veterans are an utterly unique patient population. They face difficult issues and have complex needs that are not immediately obvious to the civilian practitioner. With the number of psychologically impacted combat veterans climbing well over 1.7 million, and the ever-increasing backlog of care in the military medical system, an increasing number of military personnel are going to arrive at the doors of civilian health care providers. It is vital that we have a comprehensive understanding of this specific patient population and become adept at caring for them.

This interdisciplinary team of combat PTSD experts, all of whom have served in the Army, will show how to engage this hesitant group of wounded warriors, the best practices for assessing and treating warriors, and how, in their experiences, it is best to keep them motivated in the healing process.

Participant Alert: A short documentary of combat footage in Iraq will be shown. This footage is of realistic events in the war zone that might be disturbing to some attendees. Attendees will be encouraged to share their reactions to the documentary.

14 Beyond Exposure Alone: Brief Eclectic Psychotherapy for PTSD
(Abstract #196069)

Pre-Meeting Institute (Practice, Media Ed) **Salons 7-9, 3rd Floor**

Technical Level: Intermediate

Meewisse, Mariel, MSc[1]; Gersons, Berthold, MD, PhD[1]; Schnyder, Ulrich, MD[2]; De Vries, Giel-Jan, MS[1]; Kitchiner, Neil, MS[3]; Nijdam, Mirjam, MS[1]
[1]Center for Psychological Trauma, AMC UVA Dept of Psychiatry, Amsterdam, Netherlands
[2]Department of Psychiatry, University Hospital, Zurich, Switzerland
[3]Department of Liaison Psychiatry & Traumatic Stress Service, University Hospital of Wales, Cardiff, United Kingdom

The efficacy of psychotherapeutic and pharmacotherapeutic approaches in the treatment of PTSD can be regarded as empirically demonstrated. Overall, effect sizes seem to be higher for psychotherapy as compared with medication. Many well-controlled trials with a mixed variety of trauma survivors have demonstrated that CBT is particularly effective in treating PTSD. More specifically, exposure therapy currently is seen as the treatment modality with the strongest evidence for its efficacy. However dropout rates from studies of CBT (including EMDR) usually are around 20 percent. Up to 58 percent of patients who c-

ompleted CBT are still diagnosed with PTSD at posttreatment assessment. Furthermore, only 32-66 percent of patients included achieved good end-state functioning. There is a need to have treatment protocols based on CBT which meet more the expectations of traumatized clients. The 16-sessions Brief Eclectic Protocol (BEP) originally developed for police officers with PTSD proved to be effective in two randomized controlled trials and has been accepted in the NICE-Guidelines (2005). The second trial also showed effectivity on biological data. A trial in Zurich is still running. BEP encompasses, apart from a slightly different form of exposure, psychoeducation at the start (with the partner present), the use of letter writing to express angry feelings, the use of mementos and 8 sessions for the domain of meaning, how it changes the view on the world and on the person his or herself. It is ended with a farewell ritual. The dropout rate is lower compared to the traditional CBT. In this workshop essential techniques for protocol components will be taught including live demonstrations, video presentations of treatment sessions, and practical exercises.

15 Treating Resistant PTSD: Cognitive Behavior Therapy for Complex Trauma

(Abstract #196441)

Pre-Meeting Institute (Clin Res, Practice) **Monroe Ballroom, 6th Floor**

Technical Level: Intermediate.

Cloitre, Marylene, PhD[1]; Jackson, Christie, PhD[1]
[1]Adolescent and Child Psychiatry, NYU School of Medicine, Child Study Center, Institute for Trauma and Resilience, New York, New York, USA

This workshop will present a flexibly-applied, evidence-base treatment that systematically addresses the compromised capacities in emotional awareness, emotion regulation, and healthy attachment in survivors of complex trauma as well as the more evident symptomatology that burdens the survivor, such as PTSD, dissociation, self-injury and anger problems. The CBT protocol is organized into two 8-session phases. The first, Skills Training in Affective and Interpersonal Regulation (STAIR), focuses on the regeneration of emotional and social resources to enhance day-to-day life. The second, Modified Prolonged Exposure (MPE), focuses on the resolution of a fragmented understanding of self-and-other through the creation of a coherent and meaning-based life narrative. Presentation will include examples of and strategies for treatment resistant cases, such as skills for improving clients´ motivation and compliance. The role of the therapeutic alliance in contributing to positive process and outcome will be explored. Additionally, the promotion of good self-care skills and approaches to reduce therapeutic burn-out will be presented.

Participant Alert: The only potential for distress might come from viewing clients discussing trauma history.

16 Somatic Therapies for Traumatic Stress

(Abstract #196561)

Pre-Meeting Institute (Practice, Clin Res) **Adams Ballroom, 6th Floor**

Technical Level: Intermediate

van der Kolk, Bessel, MD[1]
[1]Boston University, Boston, Massachusetts, USA

PTSD has a profound effect on physiological arousal and a host of somatic functions—it effects the entire human organism and profoundly disturbs self-regulatory functions. Alongside psychological and pharmacological interventions, there is an extensive body of clinical, and some research based, knowledge about body-based interventions for traumatized individuals, which because of its relative complexity and body-based nature, has received little attention in mainstream PTSD circles.

The presenters in this Pre-Meeting Institute workshop will review how trauma impacts a host of somatic and self-regulatory functions and present their NIH funded work on yoga for PTSD, and their CDC funded work on theater groups with traumatized inner city youth, as well as their work with returning combat veterans from Iraq. They also will present videotaped presentations of individual sessions with traumatized individuals demonstrating sensorimotor therapy. Workshop participants will be taught specific techniques to help traumatized individuals gain control over their physiological states and to help them process traumatic experiences, including the use of breathing, movement, rhythmic interactions and body-based experiences that can lead to the resolution of traumatic states.

Participant Alert: The exercises and videotapes can be mildly distressing to people not accustomed to dealing with intense emotional reactions, but should be well tolerated by experienced clinicians.

17 Trauma Systems Therapy: Treating Traumatized Children in the System-of-Care

(Abstract #196502)

Pre-Meeting Institute (Child, Practice) **Wabash Room, 3rd Floor**

Technical Level: Intermediate

Saxe, Glenn, MD[1]
[1]Psychiatry, Children's Hospital Boston, Harvard Medical School, Boston, Massachusetts, USA

Trauma Systems Therapy (TST) is a comprehensive method for treating traumatic stress in children and adolescents that adds to individually-based approaches by specifically addressing social environmental/system-of-care factors that are believed to be driving a child´s traumatic stress problems. TST conceptualizes child traumatic stress as the interface between two conceptual axes: 1) the degree of emotional and behavioral dysregulation when a child is triggered by overt and subtle reminders of a trauma and 2) the capacity of the child´s social-ecological environment/system-of-care to protect the child from these reminders, or help the child to regulate emotions in the face of such reminders. TST is both a way of organizing services as well as a set of specific clinical interventions.

This phase-based treatment recommends various treatment modules depending on the degree of emotional dysregulation and the stability of the social environment. Treatment proceeds in phases depending on the child´s degree of emotional/behavioral regulation and environmental stability. Children move from one phase to the next based on improvements in the stability of the social environment and/or emotional regulation. TST includes plans and procedures for engaging all service providers, specific treatment planning forms that can cross systems of care, and legal consultation when needed to help a family access needed services related to recovery from traumatic stress. Specific intervention modalities that are contained within TST are home-based care, legal advocacy, emotional regulation skills training, cognitive processing skills, and psychopharmacology.

Trauma Systems Therapy has been adapted for child welfare, refugee trauma, medical trauma, co-morbid substance abuse, school-based, and residential care and is currently being used by many agencies across the United States. TST has been fully developed, manualized and can be delivered with fidelity. Results of an open trial of 110 families have been published and have revealed promising results. This presentation will review this study as well as the results from a 15-month follow up of this cohort and a small randomized clinical trial of TST vs. Treatment-as-Usual.

This Pre-Meeting Institute will review the conceptual foundations of TST, its assessment treatment planning, and treatment engagement approaches, and its ten principles of care. The audience will be encouraged to present (de-identified) clinical cases and clinical dilemmas for review.

ISTSS Special Interest Groups

Special Interest Groups (SIGs) provide members with a forum for communication and interaction about specific topic areas related to traumatic stress, and provide a means of personal and professional involvement in the activities of the society. All meeting participants are welcome to attend SIG meetings. Lunch will not be offered. If you plan on attending a SIG, you can purchase lunch outside the hotel or at a hotel restaurant prior to joining the meeting at 12:30 p.m. For room locations, see page 22.

Friday, November 14, 12:45 p.m. – 1:45 p.m.

- Diversity and Cultural Competence
- Human Rights and Social Policy
- Intergenerational Transmission of Trauma and Resilience
- Media
- Military
- Research Methodology
- Spirituality
- Terrorism and Bioterrorism Related Trauma
- Trauma Assessment and Diagnosis

Saturday, November 15, 12:45 p.m. – 1:45 p.m.

- Child Trauma
- Complex Trauma
- Creative Body and Energy Therapies
- Early Interventions
- Family Systems Approaches to Trauma
- Internet and Technology
- Primary Care and Trauma
- Psychodynamic Research and Practice
- Traumatic Loss and Complicated Grief

Special Interest Groups NOT scheduled to meet at time of printing

- Crime Justice
- Gender and Trauma
- Physical Injury, Chronic Illness and Disability
- Physiology, Pharmacotherapy and Neuroscience

Membership Information

Join the International Society for Traumatic Stress Studies and take advantage of the reduced member registration rate along with all the other benefits of being an ISTSS member. Join today using the enclosed meeting registration form or join online using the secure online membership application at www.istss.org.

ISTSS membership includes the peer-reviewed *Journal of Traumatic Stress, Traumatic StressPoints* newsletter and access to the online ISTSS members-only area including a full membership directory. ISTSS members may participate in Special Interest Groups and committees. Your ISTSS membership plays an important role in supporting international trauma research and treatment. ISTSS membership is based on a calendar year—January 1 through December 31—and dues are not prorated. Applicants joining after October 1 will become members for the following membership year.

For 2009, regular membership in ISTSS is $165 which includes both print and electronic versions of the *Journal of Traumatic Stress (JTS)*, or $145 which includes the electronic version of *JTS* only. Student membership is $90 (both print and electronic versions of *JTS*), or $70 (electronic version of *JTS* only). Students must provide their student advisor's name and e-mail address on the online application. If applying by fax or mail, e-mail advisor information to istss@istss.org, or fax to +1-847-480-9282, attn: ISTSS.

Concurrent Session 1
Thursday, November 13
8:00 a.m. – 9:15 a.m.

Ghosts and Angels in the Nursery: Curtailing the Transmission of Trauma From Parents to Children
(Abstract #198318)

Master (Child, Clin Res) **State Ballroom, 4th Floor**

Lieberman, Alicia, PhD[1]
[1]*University of California, San Francisco, San Francisco, California, USA*

There is empirical evidence that children aged birth—five become traumatized by exposure to repeated family and community violence and show developmentally specific manifestations of traumatic stress. Early trauma treatment presents special challenges because the child's traumatic stress is compounded by the parents´ traumatic response. This presentation will describe the manifestations of traumatic stress in infants, toddlers and preschoolers and the intergenerational transmission of traumatic stress from parent to child. It will also describe Child-Parent Psychotherapy (CPP), a relationship-based treatment where parents' unresolved traumatic experiences are integrated with their experiences of feeling safe and protected to generate adaptive parenting strategies that promote the child´s attachment security and emotional health. The presentation will include CPP theoretical background, clinical modalities, and case illustrations, as well as empirical evidence of efficacy from randomized controlled trials. Cultural considerations in the treatment of children and families from diverse ethnic, racial, and socioeconomic backgrounds will be discussed.

ISTSS on Sesame Street: Helping Military Families Cope With Deployment and War Injury
(Abstract #195853)

Media Presentation **Crystal Room, 3rd Floor**

Kudler, Harold, MD[1]; **Fried, Hedi, PhD**[2]; **Albeck, Joseph, MD**[3]; ***Fairbank, John, PhD***[4]
[1]*Psychiatry and Behavioral Sciences, Duke University, Chapel Hill, North Carolina, USA*
[2]*Cafe 84 Psychological Center for Survivors, Stockholm, Sweden*
[3]*Harvard University, Waban, Massachusetts, USA*
[4]*Duke University, Durham, North Carolina, USA*

When a soldier is wounded, a family is wounded. Over a million children in the United States have had at least one parent deploy for military service in Afghanistan or Iraq. To reach out to these families, Sesame Workshop brought together writers, artists, producers, clinicians, researchers, educators and others to produce "Talk, Listen, Connect." Best known for their Muppet characters, Sesame Workshop promotes its curricula to children, parents, and professionals. In TLC I (available at http://www.sesameworkshop.org/tlc/) Elmo's father is going away and Elmo and his family must cope with the long separation and uncertainty of deployment. TLC II shows what happens when a parent comes home with wounds, visible and invisible. It is designed to break the silence that often separates trauma survivors from family members. This media panel, a presentation of the Special Interest Group on Intergenerational Transmission of Trauma and Resilience, includes a screening of TLC II followed by discussion by an expert panel regarding three key questions: --(1) Does TLC II accurately reflect responses to a parent´s traumatic experience and its aftermath?; (2) Can it be expected to diminish the impact of trauma on the individual and the family?: and (3) Can it help increase that family´s resilience?

New Directions in Neuroimaging Studies of PTSD
(Abstract #195997)

Symposium/Panel (Bio Med, Res Meth) **Grand Ballroom, 4th Floor**

McFarlane, Sandy, MD[1]; **Moores, Kathryn, PhD**[2]; **Clark, Richard, PhD**[2]; **Lanius, Ruth, MD, PhD**[3]; **Bluhm, Robyn, PhD**[3]; **Williamson, Peter, MD, DpsY**[3]; **Osuch, Elizabeth, MD**[3]; **Boksman, Kristine, PhD**[4]; **Stevens, Todd, MSC**[5]; **Brewin, Chris, PhD**[6]; **Whalley, Matthew G., PhD**[6]; **Kroes, Marijn, MSC**[7]; **Vermetten, Eric, MD**[8]
[1]*The Centre of Military and Veterans' Health, Adelaide 5000, South Australia, Australia*
[2]*Flinders University of South Australia, Adelaide, South Australia, Australia*
[3]*Dept. of Psychiatry, University of Western Ontario, London, Ontario, Canada*
[4]*Hotel Dieu, Kingston, Ontario, Canada*
[5]*Robarts Research Institute, London, Ontario, Canada*
[6]*Subdept of Clinical Health Psychology, University College London, London, United Kingdom*
[7]*Wellcome Functional Imaging Laboratory, University College London, London, United Kingdom*
[8]*Central Military Hospital - Q3, University of Utrecht, Utrecht, Netherlands*

The symposium includes descriptions of specific networks that function abnormally in PTSD, using this to advance theoretical understanding of the disorder. Also described are the neural processes implicated in reliving, a core symptom of PTSD. A variety of new techniques, many involving neural feedback, offer opportunities for advancing PTSD treatment.

Working Memory and PTSD: A Neural Network Model of PTSD
This paper will present a neural network model of PTSD, based on the body of neuroimaging research that has investigated the processing of neutral and traumatic stimuli in PTSD. We propose that the primary abnormality in PTSD is a premature recruitment of networks that are typically associated with high demand tasks at much lower orders of challenge. This means that in this disorder there is a limited resource to deal with the information processing demand of complex environments. This limitation may account for the inability to process the memory of the trauma and account for many of the subjective experiences associated with this disorder. From our fMRI work the critical regions in this abnormal premature recruitment are the bilateral dorsolateral prefrontal cortex and inferior parietal lobule. Similarly, in higher demand tasks, PTSD sufferers fail to activate the hippocampus, anterior cingulate, and brain stem pons, key regions implicated in the neurobiology of PTSD. The functional connectivity studies provide valuable insights into the reciprocal networks which underpin the differences between PTSD patients and controls, and highlight the compensatory systems which sufferers with this disorder utilise to maintain and engage with their environment.

"Default Network" Abnormalities in PTSD: A fMRI Investigation
Recent neuroimaging work in healthy controls has shown the existence of a "default network" of correlated brain regions active during rest. These regions, which include the posterior cingulate, anterior cingulate and medial prefrontal cortex, and lateral parietal areas, have also been implicated in self-reflection. This study investigated whether (1) there are abnormalities in the default network in PTSD patients and (2) the extent of these abnormalities correlates with clinical measures of PTSD and dissociation. Resting state fMRI scans were obtained from seventeen healthy controls and seventeen patients with PTSD. Connectivity between the posterior cingulate and other brain areas was assessed. In healthy controls, activity in the posterior cingulate seed region was found to positively correlate with other regions of the default network. This correlation was reduced or absent in the PTSD group. Connectivity of the posterior cingulate with regions of the default network was modulated in the PTSD group by scores on the Clinician Administered PTSD Scale (CAPS) and on the Dissociative Experiences Scale. These results suggest that the integrity of the default network is compromised in PTSD and that

the extent of the deficit reflects clinical measures of PTSD as well as those of altered self perception.

Neural Correlates of Reliving in PTSD
The study was designed to investigate hypotheses about neural differences supporting flashbacks versus ordinary autobiographical memories of trauma in patients with PTSD. Twelve patients wrote in detail about their trauma and then segmented the narratives into reliving and ordinary memory sections. Words and phrases from each of these sections were selected and matched on word length and frequency, then presented within an fMRI scanner in the context of a recognition task. Distractor items were reliving and ordinary memory words and phrases from another patient´s narrative. Emotion and arousal ratings for each item were collected post-scan. We will report analyses comparing neural responses to the four sets of words and phrases, as well as responses to reliving episodes experienced spontaneously within the scanner.

Regulation of Brain Activity in PTSD
The field of applied neuroimaging in PTSD is taking rapid advantage of the opportunities that are provided by technology. These relate to PET as well as fMRI findings and range from dissociative processing and pain perception to receptor imaging and cortical thickness measurement. In this presentation a review and update is provided of these studies. The focus will be on methods, such as those used in brain gaming tools, that feed brain information back to the patient. One such method that is already seen in various treatment settings is alpha/theta training. Although little information has so far had an impact on the PTSD field, clinicians need to keep pace with the new opportunities that are becoming available. Some caution is needed before these strategies can be implemented routinely in therapeutic practice, but their strengths may be considerable. For example, virtual reality exposure within a laboratory setting may soon lend itself to a phase oriented treatment approach. This may be especially relevant for those populations in which an instrumental solution is preferred, timed in the early phase of treatment, to increase a sense of efficacy in a safe manner. Pro and cons of current applied neuroimaging opportunities will be discussed.

Dissemination of Two Evidence-Based PTSD Treatments in the Veterans Health Administration

(Abstract #196054)

Symposium/Panel (Media Ed, Practice) **Adams Ballrooom, 6th Floor**

Resick, Patricia, PhD[1]; Foa, Edna, PhD[2]; Ruzek, Josef, PhD[3]; *Karlin, Bradley, PhD*[4]; Artz, Caroline, BA[1]; Eftekhari, Afsoon, PhD[2]; Hembree, Elizabeth, PhD[2]; Kelly, Kacie, MHS[1]; Lester, Kristin, PhD[1]; Monson, Candice, PhD[1]; Ready, C. Beth, PhD[1]
[1]National Center for PTSD/Boston VA Healthcare System, Boston, Massachusetts, USA
[2]Department of Psychiatry, University of Pennsylvania, Philadelphia, Pennsylvania, USA
[3]National Center for PTSD/VA Palo Alto Health Care System, Palo Alto, California, USA
[4]Office of Mental Health Services, Department of Veterans Affairs Central Office, Washington, District of Columbia, USA

To ensure best care for veterans, VA´s Office of Mental Health Services has initiated national training programs designed to increase delivery of two evidence-based PTSD treatments: Cognitive Processing Therapy and Prolonged Exposure. Design and implementation of these large-scale dissemination initiatives, their impact to date, and lessons learned will be described.

Disseminating Cognitive Processing Therapy in VA: The Advantages and Challenges of a National Training Initiative
With the goal of bringing evidence-based treatments into practice settings serving veterans, VA Office of Mental Health Services began funding a national initiative to disseminate cognitive processing therapy (CPT) in 2006. Phase 1 was devoted to developing training materials specific for use with veteran and military patients (CPT therapist manual), developing workshop and case consultation materials, and training a cadre of trainers for Phase 2. Phase 2 consisted of 22 CPT training workshops conducted in each region of the country (845 participants), conducted between July 2007 and April 2008 followed by the availability of telephone case consultation. Obtaining the buy-in from administrators at all levels of VA was an important component of the roll-out. Phase 2 included development of a website with downloadable material, an interactive calendar, and discussion board. In late 2007, advanced tutorials were added, provided over teleconference with accompanying slides. Phase 3 will provide more basic workshops, advanced workshops and training in group CPT. Furthermore, facilitators at each hospital will be identified and trained to localize the training/supervision and work on implementation issues in their hospitals. This talk will include the formative process, accomplishments, barriers, and lessons learned in large-scale dissemination.

Disseminating Prolonged Exposure Therapy (PE) in VA: Challenges, Barrier, and Successes
Recently there has been increased recognition of the urgent need to disseminate evidence-based treatments for psychiatric disorders, to provide mental health patients served in community settings with the most efficacious treatments. to bring evidence-based treatments to veterans with PTSD, VA Office of Mental Health Services began funding a national initiative to disseminate Prolonged Exposure Therapy (PE) in 2007. In this presentation we first provide a brief overview of PE and its two main components: revisiting and recounting the traumatic memory (i.e., imaginal exposure) and gradual confrontation with trauma-related situations (i.e., in vivo exposure). We will then describe three components of the dissemination initiative. The first involves eight 4-day workshops in which 200-300 VA therapists are being trained to conduct PE, along with close supervision on their first patients to ensure accurate implementation of PE. The second component comprises three 5-day workshops in which 45 experienced VA PE therapists are taught to supervise newly trained clinicians. The third component is a three-day workshop preparing 15 PE supervisors to become PE trainers. We will discuss the development of training materials, the structure of VA training/supervision, experiences with training/supervision to date, and comparisons with previous PE dissemination initiatives.

Bringing Prolonged Exposure Treatment Into the Real-World of VA PTSD Care
Any effort to disseminate evidence-based treatments must address the challenges and opportunities related to bringing a specific treatment into a specific real-world service environment. Based on continuing assessment of a range of barriers and facilitators to dissemination of Prolonged Exposure Therapy for PTSD within the Veterans Health Administration, an ongoing national training program is described that includes features designed to address the multiple systemic, practitioner, and patient factors affecting the adoption of this treatment. Since September 2007, during the first phase of implementation, approximately 180 clinicians have received training in delivery of PE, and another 35 individuals have been trained and begun to provide individualized clinical consultation for trainees. Ongoing efforts to work with organizational leadership to address systems issues, to "market" the treatment to clinicians and treatment program managers, to create a WEB-facilitated community of PE practitioners, to enlist support from key decision-makers, and to implement a program evaluation system designed to inform the dissemination initiative are described, along with anticipated ways of addressing continuing challenges.

Integrating Spirituality in Training and Care

(Abstract #196089)

Symposium/Panel (Cul Div, Practice) **Salon 2, 3rd Floor**

Lyons, Judith A., PhD[1]; Eriksson, Cynthia B., PhD[2]; Drescher, Kent D., PhD[3]; David, Foy W., PhD[4]

[1]Trauma Recovery Program, G. V. "Sonny" Montgomery VAMC, South Central MIRECC & University of Mississippi Medical Center, Jackson, Mississippi, USA
[2]School of Psychology, Fuller Theological Seminary, Pasadena, California, USA
[3]National Center for PTSD, Menlo Park VAMC, Palo Alto, California, USA
[4]Graduate School of Ed. & Psychology, Pepperdine University & Fuller Theological Seminary, Encino, California, USA

Faith is often a major component in trauma recovery. Recovery can be complicated when acts of terror are linked to religious ideology. This panel addresses challenges encountered in conceptual integration of spirituality in clinical training and trauma care. Diversity among therapists, trainees, individual clients and group members is discussed.

Honoring Diversity of Beliefs in Group Therapy in an Academic Setting: Decision Points
Addressing spiritual conflicts and beliefs within a therapy group can be a challenging task, particularly when there is a homogeneous majority plus a minority with divergent beliefs. Operating within a governmental academic setting in which trainees come from a different belief background than most patients adds an additional degree of difficulty. The emergence of a patient-initiated religious ritual within VA therapy groups will be examined to illustrate several of the clinical and administrative decision points involved. Efforts to balance majority and minority viewpoints, evaluate contrasting needs of patients and trainees, and reframe disagreements as opportunities for practice in reconciliation and conflict management will be critiqued. [Lyons]

Religion as a Barrier and Resource in Trauma Treatment
Survivors of traumatic events hold a diversity of perspectives on faith and religion. A brief review of research on trauma and spirituality demonstrates the complexity of spiritual and religious variables in relation to traumatic exposure and distress. These religious experiences, beliefs, and values may become both barriers and resources in trauma treatment. The model of creating a spiritual narrative (Wilson & Moran, 1998) offers a framework for ethical dialogue with clients regarding their religious histories and practices. Case examples of survivors of rape and other acts of terror will be used to operationalize the development of a spiritual narrative. These cases will also demonstrate the ways that personal religious beliefs, historical religious values, and faith-oriented practices are embedded in a trauma recovery process. [Eriksson]

Spiritual/Moral Challenges of Combat: Helping Military Service Members Make Meaning of War Traumas
Spirituality may enhance resilience by buffering adverse psychological effects of combat; or it may be changed in a negative direction, becoming a casualty of war itself. The authors will describe their recent experiences in training active duty military chaplains, mental health specialists, physicians and nurses to identify "moral injuries" commonly reported by combat veterans. Four spiritual "red flags"-loss of faith, negative religious coping, guilt, and lack of forgiveness- are common reactions among combat soldiers that military care-givers need to recognize and be able to provide support as service members grapple with these formidable spiritual challenges. Evolution of a group therapy format to help veterans address their spiritual challenges and make meaning of their combat experiences in their daily lives will be described. [Drescher & Foy]

Social and Cognitive Determinants of Recovery After Trauma

(Abstract #196118)

Symposium/Panel (Clin Res, Prev El) **Wabash Room, 3rd Floor**

Littleton, Heather L., PhD[1]; Cieslak, Roman, PhD[2]; *Benight, Charles C., PhD*[3]; Nuttman-Shwartz, Orit, PhD[4]; Dekel, Rachel, PhD[5]; Lauterbach, Dean, PhD[6]; Mason, Shawn T., PhD[7]; Fauerbach, James A., PhD[8]

[1]Department of Psychology and Philosophy, Sam Houston State University, Huntsville, Texas, USA
[2]Trauma, Health, & Hazards Center, University of Colorado at Colorado Springs, Colorado Springs, Colorado, USA
[3]Department of Psychology and Trauma, Health, & Hazards Center, University of Colorado at Colorado Springs, Colorado Springs, Colorado, USA
[4]Spitzer Department of Social Work, Ben-Gurion University of the Negev, Beer-Sheva, Israel
[5]Faculty of Social Sciences, School of Social Work, Bar Ilan University, Ramat-Gan, Israel
[6]Department of Psychology, Eastern Michigan University, Ypsilanti, Michigan, USA
[7]Johns Hopkins Department of Psychiatry, Johns Hopkins University School of Medicine, Baltimore, Maryland, USA
[8]Department of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, Maryland, USA

Social cognitive theory encompasses both individual and social/environmental factors in predicting human behavior. This symposium will review several studies that have focused on the interactions between intra-individual and social/environmental factors involved in trauma recovery.

Social Support and Sexual Assault Recovery: The Mediating Role of Coping
Social support following trauma, such as sexual assault, has been conceptualized as facilitating recovery, in part through influencing trauma-related coping. For example, victims´ social networks can provide a forum for expressing emotions and developing coping strategies. Having a positive social support network can also enhance victims´ autonomy and self-confidence overall, increasing their confidence in their ability to enact adaptive strategies. Finally, members of victims´ social support networks may challenge their use of maladaptive strategies. This theorized mediated model was evaluated in sample of 106 college women who had experienced sexual assault who completed two surveys, six months apart. Specifically, social support was examined as a predictor of reduction in PTSD symptoms and trauma-related coping was examined as a mediator of this relationship. Among the 90 women who reported PTSD symptomatology at the initial assessment, perceived support from friends and a significant other significantly predicted a decline in symptomatology over six months. Maladaptive coping (avoidant and ruminative strategies) emerged as a significant mediator of this relationship. Specifically, those women who reported greater perceived social support reported less reliance on maladaptive coping. Less reliance on maladaptive coping predicted reductions in PTSD symptomatology.

Coping Self-Efficacy Mediates the Effects of Negative Cognitions on Posttraumatic Distress
Although cognitive distortions have predicted posttraumatic distress after various types of traumatic events, the mechanisms through which cognitive distortions influence posttraumatic distress remain unclear. We hypothesized that coping self-efficacy (i.e., the belief in one´s own ability to manage posttraumatic recovery demands) would operate as a mediator between negative cognitions (about self, about the world, and self-blame beliefs) and posttraumatic distress. In the cross-sectional Study 1, data collected among 66 adult female victims of child sexual abuse indicated that coping self-efficacy mediated the effects of negative cognitions about self and about the world on posttraumatic distress. The same pattern of results was found in a longitudinal Study 2, conducted among 70 survivors of motor vehicle

accidents. Coping self-efficacy measured at 1 month after the trauma mediated the effects of 7-day negative cognitions about self and about the world on 3-month posttraumatic distress. In both studies self-blame was not related to posttraumatic distress and the effect of self-blame on posttraumatic distress was not mediated by coping self-efficacy. The results provide insight into a mechanism through which negative cognitions may affect posttraumatic distress and highlight the potential importance of interventions aimed at enhancing coping self-efficacy beliefs.

The Contribution of Ways of Coping and Sense of Belonging to the College in Times of Ongoing Terror
This study examined the contribution of ways of coping and sense of belonging to the college to the distress reactions of college students in a conflict zone. The sample consisted of 500 Israeli students from a College, which is situated in an area under recurrent attacks by Qassam rockets. Participants completed self-report questionnaires assessing PTSD, additional psychiatric symptoms, daily activities, ways of coping, and sense of belonging to their college. Results revealed that elevated levels of distress, as manifested in PTSD symptoms, additional psychiatric symptoms and disruption in daily activities were associated with level of exposure to Qassam Rockets. In addition, accommodation as a way of coping and sense of belonging to the college contributed to lower stress responses, while using alcohol, disengagement and seeking support contributed to higher distress levels. Moreover, sense of belonging moderated the relations between accommodation as a way of coping and distress measures. Concluding, cognitive and social factors have both unique and interactive effects in coping with continuous threat.

Cross-Sectional and Longitudinal Predictors of Trauma Responsiveness and Symptom Persistence
Findings from two studies will be presented that examined social and cognitive variables predictive of trauma responsiveness and symptom persistence. to examine trauma responsiveness, data from the National Comorbidity Survey-Replication (NCS-R) were used to test several mediational models examining the extent to which social support (family, friends, spouse) and cognitive (i.e., worry) variables mediate the relationship between trauma exposure and PTSD presence. Worry was chosen as the primary cognitive variable as a recent prospective study (Calmes & Roberts, 2007) found that worry was predictive of anxiety. Preliminary analyses indicate that preconditions necessary to test for mediation (Baron & Kenny, 1986) were present for all variables. In addition, three mediational models were tested that examined the extent to which specific dimensions of marital relationships (i.e., disagreements, discord, and shared activities) mediate the relationship between trauma exposure and PTSD presence. to examine symptom persistence, symptoms of PTSD and social support were assessed among 630 burn victims at four time points (one month, six months, 1 year, and 2 years). Preliminary analyses suggest remarkable stability in symptoms across time. The presentation will focus on cross-lagged effects of social support on subsequent PTSD symptoms.

Gathering and Implementing Evidence on Psychological Interventions to Prevent and Treat PTSD

(Abstract #196218)

Symposium/Panel (Clin Res, Prev EI) **Salons 4-6, 3rd Floor**

Bisson, Jon, DM, FRCPSYCH[1]; Roberts, Neil, PhD[2]; Kitchiner, Neil, MSC[3]; Andrew, Martin, MBCHB, MRCPSYCH[4]; Lewis, Catrin, BA[1]; Kenardy, Justin, PhD[5]
[1]Cardiff University, Cardiff, United Kingdom
[2]Cardiff & Vale NHS Trust, Cardiff, United Kingdom
[3]Cardiff amd Vale NHS Trust, Cardiff, United Kingdom
[4]Cardiff & Vale NHS Trust, Cardiff, United Kingdom
[5]University of Quuensland, Herston, Australian Capital Territory, Australia

The results of two Cochrane Systematic Reviews on the efficacy of psychological interventions to prevent and treat PTSD will be presented. This will be followed by a description of how this evidence is being implemented into clinical practice in a Traumatic Stress service.

Multiple Session Early Psychological Intervention to Prevent and Treat PTSD: A Cochrane Review
Over the past 25 years or so clinicians have been increasingly involved in attempts to develop interventions that might mitigate against the effects of trauma and prevent the onset of chronic PTSD. For a number of years single session interventions such as Psychological Debriefing were a widely used and popular form of intervention amongst mental health professionals. Psychological debriefing came under increasing scrutiny in the 1990´s and has been the subject of a previous Cochrane Review which found no evidence for the efficacy of single session individual debriefing. Increasingly the field has turned its attention to other models of intervention, including brief forms of CBT, hypnotherapy and counselling. A number of recent studies have been conducted to evaluate some of these forms of intervention.

This presentation will describe the methodology and presents the results of a new Cochrane systematic review of 25 randomized controlled trials of psychological treatments and interventions (excluding single session interventions) aimed at either preventing PTSD or treating acute PTSD.

Cochrane Review of Psychological Treatments for Chronic PTSD
The Cochrane review of psychological treatments for chronic PTSD, first published in 2005 (Bisson and Andrew, 2005) has recently been updated. In the last three years over ten new randomised controlled trials of psychological treatments for PTSD have been published. These have been added to the trials that had already been identified and new meta-analyses performed. The results continue to confirm that trauma focused cognitive behavioural therapy and eye movement desensitisation and reprocessing are effective in the treatment of chronic PTSD and appear to be superior to other psychological treatment approaches. The increased number of studies has also allowed sensitivity analyses to be performed to determine the influence of specific factors, for example quality of the methodology, on outcomes. The methodology used and the results of the systematic review will be presented and their clinical implications discussed.

Bisson, J. & Andrew, M. (2005) Psychological treatment of Posttraumatic stress disorder. Cochrane Database of Systematic Reviews.

Trauma Focused Psychological Therapies in the Cardiff and Vale NHS Traumatic Stress Service
There is a growing demand for evidence based interventions that can prevent or treat PTSD. A shortage of therapists trained to deliver trauma focused psychological therapies (TFPT) within the United Kingdom has led to long waiting lists. In an attempt to increase therapeutic capacity and improve timely access to

evidence based interventions, the Cardiff and Vale of Glamorgan Traumatic Stress Service has developed a range of innovative approaches. These have been informed by research including the two systematic reviews presented in this symposium and aim to implement their clinical implications. This presentation will describe a range of clinical initiatives adopted by the service including an education programme for mental health professionals in small groups followed by weekly clinical supervision to enable delivery of trauma focused psychological therapies; rapid access to assessment and treatment for victims of violence referred by a national charity; and a programme to train front line health, emergency services, social services and voluntary staff to deal with distressed people following traumatic events in a sympathetic and empathic manner, acknowledging the importance of practical, pragmatic support and the lack of need for formal psychological interventions for everybody.

Elucidating the Relationship Between Substance Use and PTSD: Perspectives From the Lab to the Clinic

(Abstract #196371)

Symposium/Panel (Asses Dx, Clin Res) **Monroe Ballroom, 6th Floor**

Waldrop, Angela, PhD[1]; Brady, Kathleen, PhD[1]; Resnick, Heidi, PhD[1]; Kaysen, Debra, PhD[2]; Atkins, David, PhD[3]; Simpson, Tracy, PhD[4]; Lindgren, Kristen, PhD[2]; Owens, Gina P., PhD[5]; Chard, Kathleen M., PhD[6]; *Lewis, Jennifer, PhD*[7]

[1]*Medical University of South Carolina, Charleston, South Carolina, USA*
[2]*University of Washington, Seattle, Washington, USA*
[3]*Department of Psychology, Fuller Theological Seminary, Pasadena, California, USA*
[4]*Veterans Affairs Puget Sound Health Care System, Seattle, Washington, USA*
[5]*University of Tennessee, Knoxville, Tennessee, USA*
[6]*Cincinnati VA Medical Center, Cincinnati, Ohio, USA*
[7]*Veterans Affairs Medical Center, Ft. Thomas, Kentucky, USA*

Increases in substance abuse, problem drinking, and diagnoses of alcohol use disorders (AUD), have all been associated with trauma exposure. One difficulty with disentangling the relationship between substance use and trauma exposure is that much of the literature conducted to date has been cross-sectional and retrospective. This symposium brings together three studies examining aspects of the relationship between trauma exposure and substance use. The first speaker presents results from a laboratory experiment testing mechanisms for the relationship between risk-taking behavior and PTSD to examine aspects of the relationship between PTSD and cocaine dependence. The next speaker presents interview data from a recently trauma-exposed sample suggesting that problem drinking is associated with reduced improvement in PTSD symptoms over time. The last speaker presents data examining substance abuse history as a possible moderator of treatment outcome. These complementary approaches address various aspects of the PTSD/SUD relationship. The findings have both implications for theories of PTSD and comorbidity. Lastly, our discussant will address the implications of these findings for treatment development and implementation.

PTSD, Drug Abuse, and Risky Behavior in Women

Adults with PTSD are 2 to 4 times more likely than those without PTSD to have a comorbid SUD (Kessler et al. 1995). Sexual trauma and crack cocaine use are both associated with increased HIV risk among women. General risk-taking propensity and maladaptive decision-making may partially account for these relationships. This study used two human laboratory measures of risk-taking behavior to examine these associations among community women with PTSD symptoms (PTSD), cocaine dependence (COC), both (COC/PTSD), or neither. Risk tasks were delay discounting (DD) and the Balloon Analogue Risk Task (BART). COC/PTSD had dramatically lower CAPS scores compared to PTSD, especially hyperarousal symptoms. In the COC/PTSD group, more severe re-experiencing symptoms were associated with more cocaine use on using days. Cocaine use severity and frequency but not PTSD symptom totals had a positive relationship with DD. This pattern did not hold for BART scores. Group comparisons indicated that 1) PTSD symptoms and cocaine dependence were independently associated with higher BART scores, and 2) the COC group discounted monetary rewards more than did all other groups. The rapid assessment of risk-taking and discounting tendencies may aid in monitoring change in interventions that address maladaptive behaviors such as HIV risk.

Alcohol Problems and the Course of Posttraumatic Stress Disorder in Female Crime Victims

Complex relationships between PTSD and problem drinking have been well-documented. Although some studies have demonstrated PTSD increasing drinking, others suggest alcohol problems may be associated with a more severe course of PTSD. However, little longitudinal research with acute trauma samples has been conducted. The present study examines the impact of alcohol use and consequences on the course of PTSD. Participants were seen 1, 3, and 6 months after exposure to a sexual or physical assault (n = 65). Measures include the Timeline Followback procedure, the Drinc, and the Clinician Administered PTSD Scale. There was a significant interaction between current AUD and days since the assault such that those with alcohol abuse/dependence have a slower recovery from PTSD symptoms. The model suggested participants with current AUD have fewer PTSD symptoms immediately after the trauma, but do not show the typical recovery curve. On average, they changed little over the 6 months. Higher levels of drinking consequences also appeared to predict slower recovery, predominantly at high levels of alcohol consequences. Results highlight the importance of longitudinal methodologies in elucidating the nature of the relationship between PTSD and alcohol misuse. Findings suggest early intervention strategies for women presenting post-trauma with alcohol problems may be indicated.

Relationships Among Substance Abuse History, Anger, and PTSD for Veterans in Residential Treatment

The authors will discuss changes in Veterans cognitions after attending a 7 week residential PTSD program, using Cognitive Processing Therapy. One hundred and eighty-two veterans were screened upon admission to the program and again at discharge. Participants were assessed using the Clinician Administered PTSD Scale and completed self-report measures including the State-Trait Anger Expression Inventory-2 and Beck Depression Inventory. History of substance abuse or dependence was also assessed. Seventy-three percent of respondents were male; two thirds of the sample were Caucasian and one third were African American. Fifty-six percent of participants served in the Vietnam War, 25% post-Vietnam War, 14% Persian Gulf War, 3% Iraq, and 1% Afghanistan. Results of a repeated measures MANOVA indicated significant main effects for drug dependence history, time, and the interaction between time and drug dependence history. Follow-up analyses found significant differences between veterans with and without a drug history for anger expression at pre- and post-treatment. Initial findings suggest that anger expression may be particularly relevant in treatment with individuals with a drug dependence history. Implications for care will be discussed.

Papers
Interpersonal Violence

Salons 7 – 9, 3rd Floor

Chair: Lars Weisaeth, MD, PhD,
Norwegian Centre for Violence and Traumatic Stress Studies, Ullevål University Hospital, Oslo, Norway

Exposure to Assault Violence

(Abstract #195978)

Paper Presentation (Practice, Asses Dx)

Johansen, Venke A., PhD[1]; Weisaeth, Lars, MD, PhD[2]
[1]Resource Centre on Violence, Traumatic Stress and Suicide Prevention, Western Norway, Haukeland University Hospital, Bergen, Norway
[2]Norwegian Centre for Violence and Traumatic Stress Studies, Ullevål University Hospital, Oslo, Norway

The purpose was to evaluate short- and long-term psychological consequences and the impact on quality of life (QoL) after exposure to physical assault.

A longitudinal design with three repeated measures (n=143 at T1). Questionnaires: IES -22, PD (7 items), Social Provisions Scale, Generalized Self-Efficacy Scale and WHOQOL-Bref. The predictors of PTSD symptoms were analysed in relation to PD, physical injury, perceived life threat, prior experience of violence, perceived social support (PSS), and perceived self-efficacy (PSE). Furthermore the predictive value of PTSD symptoms for QoL was examined.

Findings showed a high prevalence of PTSD symptoms. Perceived life threat was a predictor of PD and early PTSD predicted subsequent PTSD. Low PSE was a predictor of PTSD. Furthermore, lack of PSS was a predictor of PTSD symptoms at T3. The presence of PTSD symptoms predicted lower QoL, both from an acute and prolonged perspective.

Our findings support the understanding of PTSD as a complex phenomenon. Being aware of symptoms such as perceived life threat and PD during the event and PTSD symptoms in the acute phase, would help to identify some of those in need of special follow-ups.

Self-Medication of PTSD by an Amphetamine-Like Substance: Effect on Paranoia in Somali Ex-Combatants

(Abstract #196007)

Paper Presentation (Mil Emer, Asses Dx)

Odenwald, Michael, PhD[1]; Hinkel, Harald, PhD[2]; Elbert, Thomas, PhD[3]
[1]University of Konstanz, Konstanz, 78464, Germany
[2]Multi-Country Demobilization and Reintegration Program, The Worldbank, Goma, Congo, Democratic Republic of (Zaire)
[3]University of Konstanz, Konstanz, Germany, Germany

The leaves of the khat shrub (Catha edulis) contain the amphetamine-like cathinone and are not restricted by law in Somalia. Binge use and early onset in life are related to the development of psychotic disorders.

Using a cross-sectional design, trained local staff interviewed 8,723 military personnel in Somalia. We used selected items from the Composite International Diagnostic Interview, from the Somali version of the Posttraumatic Stress Diagnostic Scale, and assessed attempts to self-medicate PTSD. Group differences were explored using non-parametric and Chi2 tests.

Respondents with PTSD more frequently indicated that khat helps them to forget war experiences (77.6% vs. 16.0%, p MORE THAN ARROW .001). Khat chewers with PTSD had a higher mean khat intake in the previous week (18.8 `bundles´ ± 16.3 vs. 8.7 ± 10.2, p MORE THAN ARROW .001). Respondents who self-medicate PTSD had the highest intake (19.4 ± 16.5) and clearly differed from those participants with PTSD who did not (7.5 ± 5.2; p < .001). In our regression model, self-medication was the strongest predictor for paranoia (OR = 4.179, CI99% 1.012 – 8.677; Nagelkerke´s R .309). Among the 287 khat chewers with PTSD and self-medication the prevalence of paranoia reached 31.4%.

We document self-medication of PTSD in a non-western war-zone. In Somalia, attempts to self-medicate PTSD by using khat cause paranoid symptoms.

Correlates of Symptom Reduction in Treatment Seeking Survivors of Torture

(Abstract #196408)

Paper Presentation (Civil Ref, Clin Res)

Raghavan, Sumithra, BA[1]; Rosenfeld, Barry, PhD[2]; Keller, Allen, MD[2]; Rasmussen, Andrew, PhD[2]
[1]Fordham University, Bronx, New York, USA
[2]New York University, New York, New York, USA

The torture treatment movement is into its second quarter century, and yet empirical examinations of clients´ improvement over time remain scarce. The present study examines correlates of symptom reduction in a multinational refugee sample (N = 189) attending a torture treatment center in New York City. Clients were assessed for clinical symptoms using the Brief Symptom Inventory and Harvard Trauma Questionnaire during the intake process and six months following intake. Data revealed statistically significant decreases in clinical symptoms at follow-up. Although there were no demographic correlates of improvement, securing immigration status was predictive of clinical improvement in the full sample. Regression models revealed that individual therapy, psychiatric appointments, and attendance at educational sessions were predictive of improvement beyond the effects of immigration status. A substantial number of clients (n = 80) displayed clinically significant improvement on at least one of the measures, as reflected by a decline in scores by at least one standard deviation. A subsample of clients who endorsed elevated levels of clinical distress at intake (n = 90) also displayed statistically significant improvement, which was moderated by immigration status alone. Interpretation of these findings and implications for torture treatment centers will be discussed.

Addressing Ethical Dilemmas of Trauma Mental Health in Contemporary Wars and Terrorism

(Abstract #196147)

Workshop/Case Presentation (Sos Ethic, Civil Ref) **Salon 3, 3rd Floor**

Stone, Andrew, MD[1]; Weine, Stevan, MD[2]; Henderson, Schuyler, MD[3]
[1]VA Medical Center Philadelphia and Univ. of Pennsylvania, Philadelphia, Pennsylvania, USA
[2]University of Illinois at Chicago, Chicago, Illinois, USA
[3]Division of Child and Adolescent Psychiatry, Columbia University, New York, New York, USA

The trauma paradigm has varying degrees of explanatory power in the current sociopolitical context. The relationship of trauma to political relations, mental health services, and professional obligations is exposed respectively in explanatory models of terrorism focusing on personal traumatization (Speckhard 2006), gaps uncovered by journalists in services for Iraq and Afghanistan veterans implicated in murders since returning home (Sontag and Alvarez 2008), and treatment of veterans subject to possible redeployment (Stone 2008). These cases use trauma models to explain psychopathology at the intersection of war and civilian life. Contemporary wars and terrorism place trauma professionals at this intersection. This position is fraught with ethical dilemmas about the use of trauma explanatory models with political, social, and professional consequences. This workshop will explore these ethical concerns via specific cases. The presenters will apply a

discourse structured on the nature of personal, professional, institutional and humanitarian obligation that has been previously described for mental health leadership (Weine 2006). We claim that through collaborative discourse on the nature of obligations, trauma mental health professionals will be better prepared to address these crucial ethical concerns. Participants will be invited to pose other examples for discussion

Creating a Statewide Trauma-Informed System of Care

(Abstract #196465)

Workshop/Case Presentation (Sos Ethic, Commun) **Salon 1, 3rd Floor**

Franks, Robert, PhD[1]; **Lang, Jason, PhD**[2]
[1]*Connecticut Center for Effective Practice, Yale University, Farmington, Connecticut, USA*
[2]*Connecticut Center for Effective Practice, Farmington, Connecticut, USA*

This workshop will provide a case study of the work underway in the State of Connecticut to develop a trauma-informed system of care in behavioral health, child welfare and juvenile justice. Authors will present recent efforts to identify a range of trauma-informed services, to develop mechanisms for dissemination and quality assurance for evidence-based practices, and to develop agency policies and procedures to guide and provide a context for best practices. Presenters will detail efforts in Connecticut and provide an overview of other similar statewide efforts across the United States. Challenges, barriers and achievements will be highlighted.

Audience members will be engaged to share their own efforts in developing systemic policies and procedures and discuss common goals and activities. Recommendations and opportunities for further collaboration will be explored.

Thursday, November 13
9:30 a.m. – 10:45 a.m.
Keynote

Realpolitik and the Pursuit of International Criminal Justice: A Perennial Conflict?

(Abstract #196670)

Keynote Address **Grand Ballroom, 4th Floor**

Bassiouni, M. Cherif, JD, LLB, LLD, LLM[1]
[1]*DePaul University College of Law, Chicago, Illinois, USA*

It is commonly said that "what is terrorism to some is heroism to others". Historically, states have benefited from the monopoly of violence to the exclusion of others. More recently, enhanced by globalization, individuals and small groups have effectively challenged states´ monopoly on violence and have been able to use a strategy of low-level violence with considerable socio-psychological and political impact. At the same time, many governments have used fear in order to expand their powers and political durability by enhancing the public perception of vulnerability, in many instances violating or abridging individual civil rights, although these reactionary fear-tactics by governments have usually not proven to be effective.

The international legal regimes applicable to the regulation of collective violence are hopelessly mired in government politics. The law of armed conflict favors states against insurgent groups, even though the latter may have valid legitimacy claims. Conflicts of an internal character are outside the purview of the protection of international humanitarian law and thus favor incumbent governments irrespective of their illegitimacy. Other legitimate claims advanced by non-state actors find themselves without peaceful resolution mechanisms and thus appear to leave them only with the option of resorting to violence.

In reality, we need a genuinely modern international legal order to ensure that terror-violence is prevented and that all victims have access to systems of justice and redress. In this year of the 60th anniversary of the Universal Declaration of Human Rights, while applauding that visionary declaration, we need to review its impact through the last six decades, and apply its spirit to address the many issues involving our planet and its inhabitants today.

Concurrent Session 2
Thursday, November 13
11:00 a.m. – 12:15 p.m.

Recent Developments in PTSD Treatment Outcome Research

(Abstract #195919)

Symposium/Panel (Clin Res, Practice) **Wabash Room, 3rd Floor**

Resick, Patricia, PhD[1]; **Rothbaum, Barbara, PhD**[2]; **Foa, Edna, PhD**[3]; **Bryant, Richard, PhD**[4]
[1]*Women's Health Sciences Division, National Center for PTSD/Boston VA Healthcare System, Boston, Massachusetts, USA*
[2]*Department of Psychiatry, Emory University, Atlanta, Georgia, USA*
[3]*Department of Psychiatry, University of Pennsylvania, Philadelphia, Pennsylvania, USA*
[4]*School of Psychology, University of New South Wales, Sydney, New South Wales, Australia*

Although cognitive behavior therapy is the treatment of choice for PTSD, there is a need to develop more effective treatments and to determine factors that influence treatment response. This symposium presents four studies that address treatment outcome research. The initial paper provides an overview of treatment predictors from two trials of cognitive processing therapy. The second paper reviews the differential responses to treatment of survivors of terrorist attacks and motor vehicle accidents. The third paper reviews predictors of outcome following EMDR and Prolonged Exposure. The fourth paper overviews a series of studies that have used structural and functional fMRI to identify the neural factors that predict response to CBT and also the impact of CBT on neural functioning.

Pretreatment Predictors of Treatment Response Across Two Studies of Cognitive Behavioral Treatment for PTSD
Patricia A. Resick, Jaimie Gradus, and Shireen Rizvi

This presentation examines predictors of treatment outcome from two studies of female participants with PTSD using hierarchical linear modeling (HLM). Study 1 compared CPT and PE (n= 145); study 2 compared cognitive therapy (CPT-C) and written accounts (WA) (n= 97). Study 1 found being younger or having lower IQ predicted dropout from treatment. Higher depression and guilt at pretreatment were associated with greater treatment response. Increased anger predicted dropout of PE, while older women in PE and younger women in CPT had the best outcomes. In Study 2, among those receiving CPT-C age was associated with less improvement. More dysfunctional cognitions (PBRS) were associated with more improvement. In contrast, for WA participants, PBRS and age did not predict changes in PTSD over time. Unlike CPT-C, anger and depression predicted treatment response among WA participants. These findings suggest that there might be different predictors of response to cognitive therapy versus exposure therapy.

Efficacy of the Developmentally Adjusted Prolonged Exposure Protocol With Posttraumatic Youth: Comparing Victims of Terrorist Attacks With Victims of MVA
Foa, E.B, Gilboa-Schechtman, E., Shafran, N., Harish-Avidan, S.Daie, A., Rachamim, L. and Apter, A.

This study examined (a) clinical presentation of posttraumatic distress in pediatric victims of terrorist attack (TA) and motor vehicle accident (MVA) survivors; (b) efficacy of a developmentally adjusted prolonged exposure (PE) treatment in an open trial in TA vs. MVA; and (c) the efficacy of PE vs. time-limited psychodynamic therapy (TLDT) among adolescents in a randomized control trial (RCT). The TA and MVA victims were mostly similar on distress measures. The open trial indicated effect sizes of PE (intent-to-treat) were 1.78, 1.51 and 1.3 for PTSD, depressive and general anxiety symptoms, respectively. The RCT indicated that the effect sizes for PE and TLDT were 1.53, 1.45 and 2.7 and 1.07, 1.28 and

1.48 for PTSD, depressive and general anxiety symptoms, respectively. PE resulted in greater loss of PTSD diagnosis compared to the TLDT (88% and 50%). Based on independent clinical evaluation of global functioning, the effect size of PE and TLDT were 4.74 and 1.42, respectively.

Predictors of Treatment Response for EMDR and Prolonged Exposure
Barbara Rothbaum

Predictors for response to treatment in a controlled study aimed to evaluate the relative efficacy of Prolonged Exposure (PE) and Eye Movement Desensitization and Reprocessing (EMDR) compared to a no-treatment wait-list control (WAIT) in the treatment of PTSD in adult female rape victims were examined. In this study, 74 participants with PTSD were randomly assigned to one of the three experimental conditions to achieve 20 completers per group. Independent Assessors blind to the treatment condition administered standard measures of PTSD and related symptoms. Improvement in PTSD, depression, dissociation, and state anxiety was significantly greater in both PE and EMDR group than the WAIT group. PE and EMDR did not differ significantly for change from baseline to either post-treatment or 6-month follow up measurement for any quantitative scale. EMDR subjects with 2 or more comorbid diagnoses, however, improved significantly less than all other active treatment subjects. At post-treatment and 6-months, 95% and 94% of PE subjects and 75% and 74% EMDR subjects no longer met *DSM-IV* PTSD criteria, respectively. At the 6-month follow-up assessment, 78% of those who received PE and 35% of those who received EMDR met criteria for good end state functioning (p=.017).

Neural Predictors of CBT Response
Richard A. Bryant

Animal and human studies have indicated that the medial prefrontal cortex and amygdala are implciated extinction learning. CBT is a form of extinction learning and may involve the same neural networks. This study recruited patients with PTSD (N = 14) and assessed them using structural and functional MRI as they viewed fearful faces. Patients were then treated with 8 sessions of CBT and assessed 6 months later. In terms of structural MRI, good response to CBT was significantly predicted by volume of rostral anterior cingulate cortex. In terms of functional MRI, poor response to CBT was predicted by greater activation of the bilateral amygdala during subliminal presentation of fearful faces. Patients' reductions of PTSD symptoms over treatment resulted in greater recruitment of anterior cingulate cortex during fear processing after treatment. These results are discussed in terms of extinction models of exposure therapy and point to possible means to enhance treatment response.

Complex Trauma in Children and Adolescents: Conceptualization and Assessment

(Abstract #196052)

Symposium/Panel (Child, Asses Dx) **State Ballrooom, 4th Floor**

Nader, Kathleen, DSW[1]; Fletcher, Kenneth, PhD[2]; Ford, Julian, PhD[3]; Briere, John, PhD[4]; Pelcovitz, David, PhD[5]; van der Kolk, Bessel, MD[6]; *DeRosa, Ruth, PhD*[7]
[1]Director, Two Suns, for the Assistance of Traumatized Children and Adolescents, Cedar Park, Texas, USA
[2]Department of Psychiatry, University of Massachusetts Medical School (Worcester), Worcester, Massachusetts, USA
[3]Department of Psychiatry, University of Connecticut School of Medicine, Farmington, Connecticut, USA
[4]Departments of Psychiatry and Psychology, University of Southern California, Los Angeles, California, USA
[5]Department of Psychology and Education, Yeshiva University, New York, New York, USA
[6]Department of Psychiatry, Boston University School of Medicine, Brookline, Massachusetts, USA
[7]Co-Director, Cognitive Behavioral Associates, Great Neck, New York, USA

Researchers/clinicians will discuss important questions regarding the clinical and diagnostic conceptualization of complex trauma in children (AKA Developmental Trauma Disorder). Panel members will discuss the pros and cons of a separate diagnosis vs. PTSD + comorbidities, attachment security issues, age of onset, findings for maltreated youth, and taskforce data findings.

Is a Complex PTSD Diagnosis Needed and Justified?
Ford, J.

Conceptualizations of complex trauma have focused on traumatic stressors that compromise the formation or maintenance of secure attachment bonds with primary caregivers (Brown, in press; Siegel, 2001) and/or biopsychosocial development ("developmentally adverse interpersonal Trauma," Ford, 2005). These formulations and associated models of complex PTSD in childhood (e.g., "Developmental Trauma Disorder," van der Kolk, 2005) raise a critical clinical and research question: "Is a Childhood Complex PTSD Diagnosis needed and justified?" This clinical/nosological and research question is central to the consideration of revisions to the diagnosis of PTSD for children. The formalization of a new childhood complex PTSD diagnosis will be discussed by considering the evidence from clinical case studies involving complicated trauma histories and psychiatric/behavioral comorbidities. Evidence suggests that there are discernable trajectories of attachment security versus insecurity and normative versus Posttraumatic psychobiological adaptations (Ford, in press) that have clinical utility (First et al., 2004) as precursors to the acquisition of self-regulation versus dysregulation of emotion, bodily functioning, cognitive information processing, and relationships in infancy, childhood, and adolescence.

Do We Need a Child Complex Trauma Diagnosis, or, Instead, a Way to Diagnose Ongoing Attachment Symptoms Beyond Age 5?
Briere, J. & Hodges, M.

Although it is clear that children and adolescents may present with a variety of symptoms sometimes informally referred to as complex PTSD or developmental trauma disorder (DTD), such clinical presentations may primarily reflect the effects of early disturbed attachment as it is shaped by biological, sociocultural, and trauma-specific phenomena in subsequent development. It is suggested that the critical symptoms associated with proposed complex trauma diagnoses are those related to problems in self-awareness, affect regulation, and relatedness, all of which may reflect disturbed attachment as it presents in older childhood and adolescence. However, the *DSM* has no way of diagnosing severe attachment disturbance after age 5, implying that such dysregulation terminates at that point. Instead, young children may be given the (relatively undifferentiated) diagnosis of reactive attachment disorder, and then later receive attachment-unrelated diagnoses as they age into older childhood, typically concluding with cluster "A" or B" personality disorder diagnoses in late adolescence. Although DTD acknowledges attachment disturbance as an important etiology, perhaps what is needed are *DSM* diagnoses that specifically index ongoing and chronic severe attachment disturbance as it presents in older children and adolescents. The relevant literature will be reviewed.

Can Complex PTSD be an Adolescent Onset Problem?
Pelcovitz, D.

Difficulties with affect regulation and relationships with caregivers and peers, use of denial and dissociation as coping mechanisms, alterations in self-concept, somatic complaints and struggles with identity and finding meaning in their lives are well documented in a variety of clinical and research reports on adolescent trauma victims. An important question in discussing the need for a new complex PTSD diagnosis for children is whether the constellation of symptoms described should be limited to children who experienced traumatic events early in their histories or whether there is a subset of adolescents who experience abuse or other types of trauma who develop this constellation of symptoms in spite of relatively healthy preadolescent experiences. Utilizing a

combination of case vignettes and research data on physically abused adolescents and treatment of complex PTSD in this population, the question of whether a new complex PTSD for children should be broadened to include adolescent onset trauma.

A Study of Developmental Trauma Disorder by the NCTSN *DSM-V* Taskforce
van der Kolk, B., Spinazzola, J., Stolbach, B., Dekell, R., Kisiel, C. & Pynoos, R.

Purpose: Each year over 3,000,000 children are reported to the authorities for abuse and/or neglect in the US. Research has well documented that adverse childhood experiences have a powerful relation to adult health a half-century later and expressed as increased depression, suicide attempts, alcoholism, drug abuse, sexual promiscuity, domestic violence, obesity, and a variety of physical illnesses. Childhood trauma is probably our nation´s single most important public health challenge.

Method: Isolated traumatic incidents tend to produce discrete conditioned behavioral and biological responses to reminders of the trauma, as captured in the PTSD diagnosis. In contrast, chronic maltreatment has pervasive effects on the development of mind and brain. This presentation will include data on developmental trauma from four different databases comprising over 80,000 children.

Conclusion: We will present the provisional diagnostic criteria for Developmental Trauma Disorder by the NCTSN *DSM* V Taskforce.

The Nature and Extent of Traumatic Stress in Refugees

(Abstract #196203)

Symposium/Panel (Asses Dx, Civil Ref) **Crystal Room, 3rd Floor**

Bryant, Richard, PhD[3]; Hinton, Devon, MD[1]; Rasmussen, Andrew, PhD[2]; Nickerson, Angela, BSC[3]; de Jong, Joop, PhD[4]
[1]Department of Psychiatry, Harvard University, Cambridge, Massachusetts, USA
[2]School of Medicine, New York University, New York, New York, USA
[3]School of Psychology, University of New South Wales, Sydney, New South Wales, Australia
[4]Department of Psychiatry, Vrije Universiteit Amsterdam, Boston University School of Medicine, Amsterdam, Amsterdam, Netherlands

This symposium addresses the issue of traumatic stress in refugee populations. There are currently over 20 million refugees in the world today, and significant proportions suffer posttraumatic stress conditions. These papers provide data concerning the extent to which western conceptualizations adequately explain the distress experienced by refugee populations across different cultures. The first two papers focus on the extent to which local idioms capture the extent of the problems experienced by different cultures, and how these local conceptualizations map onto western constructs, such as PTSD. Subsequent papers focus on the nature and extent of traumatic stress and depression on refugee populations, and highlight the role of ongoing threat and anticipatory anxiety on the clinical presentation of populations who have been displaced under conditions of threat.

Key Idioms of Psychological Distress Among Cambodian Refugees
Devon Hinton

Though PTSD can be diagnosed in non-Western populations, the question remains as to whether local idioms of distress play a major role in the local shaping, experiencing, and understanding of trauma-related disorder. The current study examines two key idioms of distress in Cambodian context, "wind attacks" (kaeut khyol), the common local way of describing anxiety symptoms in terms of the local ethnophysiology, and "thinking a lot" (kut caraeun), a local idiom indicating that the mind is overactive, thinking of various topics from current life concerns to past events. Based on a large sample of Cambodian refugees attending a psychiatric clinic in the United States, we examine the ability of these idioms of distress to predict PTSD and PTSD severity (using the PCL). The results suggest that these cultural syndromes should be specifically evaluated and addressed for treatment to be empathic and effective.

Idioms of Psychological Distress Among Darfuri Refugees
Andrew Rasmussen

The presumption that Western measures of distress are valid for African refugees ignores a rich tradition of indigenous healthcare that includes what Western practitioners would call psychological distress (Patel, 1995), as well as international calls to tailor assessment methods to local populations in disaster settings. We used a rapid ethnographic assessment with focus groups for free listing and traditional healers as key informants to create assessment tools for Darfuris living in eastern Chad. Most problems reported by Darfuri refugees fell into two distress constructs: hozzun (literally "sadness"), and majnun ("madness"). These disorders were both based in trauma and loss, with majnun being a more severe reaction than hozzun. Overlap between PTSD and hozzun was comprised of what Western psychologists would recognize as traumatic intrusion, whereas overlap between PTSD and majnun was comprised of emotional numbing. Most of the remaining indicators of hozzun overlapped with major depression, whereas remaining majnun symptoms were more psychotic in nature, accompanied by a few of the more severe depression symptoms. We report on the differential ability of hozzun, majnun, PTSD (using the PCL-C) and depression (using the BSI Depression subscale) to predict functional impairment using a representative sample of 848 refugees drawn from two camps.

Mental Health and Postmigration Adjustment in the Mandaean Refugees in Sydney, Australia: A Longitudinal Study.
Angela Nickerson and Richard A. Bryant

The Mandaeans are a cultural and religious group predominantly from Iraq and Iran who have been subject to centuries of persecution. A longitudinal survey was conducted examining the psychological functioning of the Mandaean refugee community in Sydney at two time-points. Participants in this study included 241 Mandaeans who took part in the first survey in 2003, and 315 who took part in the second survey in 2006-2007. The community´s psychiatric status was assessed including posttraumatic stress disorder, depression, grief, anger and mental health-related disability. Pre-migration trauma, postmigration living difficulties and the effect of government policies including immigration detention and temporary protection on Mandaean mental health were also examined. At the time of the first survey, the community exhibited high levels of psychopathology and functional disability. Overall, the community´s psychological status had improved by the second assessment. This may be related to the large-scale change in visa status that occurred in the community between the two surveys. The relative importance of various factors in predicting long-term mental health in the Mandaeans will be discussed. In addition, the effect of ongoing threat on the psychological functioning of this community will be explored.

Effectiveness and Cost-Effectiveness:
Effectiveness of Western Style Treatments in Non-Western Community Settings
Joop de Jong, Ivan Komproe, Herman Ndayisaba, Sotheara Chhim

We did a naturalistic multi-site cost effectiveness study to assess the effectiveness of the implementation of psychosocial programs on mental health, psychosocial and rehabilitation in five low-income countries affected by violence (Burundi, Gaza, Cambodia, Nepal and Uganda). In a naturalistic design, participants received either individual care with psychotropics, individual care without psychotropics, or supportive group therapy. Treatment conditions were compared with a control group in areas where mental health services are not available. The participants were interviewed before treatment (T1) and at 5 months post treatment (T2). The effects of the interventions were evaluated in terms of a) psychological distress, b) psychiatric symptomatology, c) disability and d) limitations due to emotional problems, social functioning, physical functioning. Results will be presented in terms of effect sizes and

costs and benefits of interventions for Burundian patients (n = 236) and controls (n=249) as well as Cambodian patients (n=279) and controls (n=231).

Psychological Outcome of Motor Vehicle Accidents

(Abstract #196216)

Symposium/Panel (Clin Res, Asses Dx) **Monroe Ballroom, 6th Floor**

Kim, Yoshiharu, MD[1]; Matsuoka, Yutaka, MD[1]; Schnyder, Ulrich, MD[2]; Freedman, Sara, PhD[3]; *Ursano, Robert, MD[4]*
[1]National Institute of Mental Health, Kodaira, Tokyo, Japan
[2]University of Zurich, Zurich, Switzerland, Switzerland
[3]Hadassah University Hospital Jerusalem, Jersualem, Israel
[4]Uniformed Services University, Kensington, Maryland, USA

Motor vehicle accident (MVA) is a common trauma, deteriorating the quality of life and causing chronic mental disorders such as PTSD. As the mortality cases have been decreasing in many countries, the number of rescued and wounded victims has been increasing, so as to enlarge the population with high risk for PTSD and other psychosocial problems. MVA also provides a unanimous cohort for preventive intervention for PTSD, in that it is accompanies little diversity in the nature of trauma Cultural factors may influence the outcome, but as yet there is no comparable data on the mental health of of MVA victims cross-culturally. We here present the results of three longitudinal studies conducted in different countries, namely, Japan, Switzerland and Israel. The data from Israel study will show the efficasy of multi-modality of early intervention, which is also very suggestive for the treatment of victims of other types of trauma.

Psychiatric Morbidity Following a Motor Vehicle Accident and Its Impact on Health-Related Quality of Life
Yutaka Matsuoka, Daisuke Nishi, Satomi Nakajima, Yoshiharu Kim

Purpose: By assessing the incidence of psychiatric illness after involvement in a motor vehicle accident (MVA) in Japan, we studies the predictors of psychiatric illness, and the association between psychiatric illness and health-related quality of life (HRQOL).

Method: 100 injured patients were interviewed immediately at an emergency department and 1-month after involvement in a MVA. Main outcome measures were the Mini-International Neuropsychiatric Interview, CAPS, and the Medical Outcomes Study Short Form-36 Health Survey (SF-36).

Results: Thirty-one patients showed some form of psychiatric illness at 1-month follow-up. The majority of illnesses consisted of depression (major depression, n = 16; minor depression, n = 7) and PTSD (full PTSD, n = 8; partial PTSD, n = 16). Psychiatric morbidity was predicted by a sense of life threat (odds ratio [OR] = 4.2), elevated heart rate (HR) (OR = 1.6), and higher IES-R intrusion subscale score (OR = 1.1). Patients with psychiatric illnesses had lower SF-36 scores than those without psychiatric illness.

Conclusion: This study showed that psychopathology following a MVA in Japan is common and is associated with poor HRQOL. A combination of a sense of life threat, HR and IES-R intrusion allowed for significant prediction of psychiatric morbidity.

Quality of Life Following Accidental Injury
Ulrich Schnyder, Lutz Wittmann, Hanspeter Moergeli, Stefan Buchi

Purpose: Using latent growth curve modelling, we studied the change of quality of life (QOL) over one year in severely injured accident survivors, and investigated the interaction of loss of QOL with psychopathological and social variables.

Methods: 323 recent accident survivors who were hospitalized for at least two consecutive nights were assessed within five days of the trauma, six and twelve months post-accident. Measures included the PDEQ, CAPS, HADS, and PRIME-MD. to assess QOL, we used Henrich and Herschbach´s Questions on Life Satisfaction FLZ.

Findings: QOL decline (mean values: T1=76.8, T2=65.2, T3=60.3) was best described by a linear model. Both intercept and slope differed significantly from zero. Whereas the intercept showed significant variance, the slope did not. Presentation of findings will focus on the interaction of the decrease in QOL with posttraumatic pathology and social variables.

Conclusions: In a great majoprity of survivors, QOL declines steadily over one year following accidental injury. This decline is not isolated but interacts with further psychopathological and social developments. Implications for therapeutic interventions are discussed.

Preventing PTSD by Early Treatment in Road Traffic Accidents and Other Events
Sara Freedman, Arieh Y. Shalev, Rhonda Addesky, Yael Errera, Yossi Israeli-Shalev, Tamar Peleg

Background: Chronic PTSD is disabling and treatment resistant. We evaluated the ability of cognitive therapy (CT), prolonged exposure (PE), an SSRI and delayed PE to prevent PTSD in survivors of road traffic accidents (80%) and other events.

Methods: Adult survivors of traumatic events with Acute PTSD were randomized (equipoise-stratified randomization) to 12 sessions / 12 weeks of CT (n=51) or PE (n=73), or to blindly receive either escitalopram (20mg) or placebo (n=52), or to remain on a waitlist (WL) and receive PE three months later. Qualified clinicians, blind to treatment allocation, administered the Clinician Administered PTSD Scale (CAPS) before and after treatment.

Results: CT and PE similarly reduced the prevalence of PTSD at five months (18.2% and 21.4%) whereas the escitalopram, placebo and WL conditions yielded 61.9%, 58.8% and 57.4% PTSD ($p<0.001$). Early and Late PE similarly reduced the prevalence of PTSD at eight months (21% and 19%). Survivors with partial PTSD recovered equally well with or without treatment.

Comment: In this presentation we will compare the results of road traffic accidents victims with those of other traumatic events.

The Relationship Between Killing, Mental Health, and Functional Impairment in Veterans and Police

(Abstract #196376)

Symposium/Panel (Mil Emer, Sos Ethic) **Adams Ballroom, 6th Floor**

Maguen, Shira, PhD[1]; McCaslin, Shannon, PhD[1]; Inslicht, Sabra, PhD[1]; Metzler, Thomas, MA[2]; *Marmar, Charles, MD[2]*; Litz, Brett, PhD[3]; Seal, Karen, MD[2]; Lucenco, Barbara, PhD[4]; Gahm, Gregory, PhD[5]; Reger, Mark, PhD[5]
[1]University of California, San Francisco and San Francisco VA Medical Center, San Francisco, California, USA
[2]University of California, San Francisco, San Francisco, California, USA
[3]Psychiatry, VA Boston Healthcare System and Boston University, Boston, Massachusetts, USA
[4]Washington State Dept. of Social and Health Svcs, Olympia, Washington, USA
[5]Madigan Army Medical Center, Tacoma, Washington, USA

This symposium will examine the impact of killing among Vietnam veterans, police officers, and Operation Iraqi Freedom (OIF) soldiers. The relationship between duty-related killing, mental health symptoms, and functional impairment will be examined. These findings will be presented within a larger theoretical framework.

The Impact of Killing in Vietnam Veterans
The purpose of this study is to examine the impact of killing among Vietnam veterans serving in a war zone. Utilizing the NVVRS clinical dataset, we examined the impact of killing after controlling for exposure to traditional combat. When examining PTSD as the outcome variable, we found killing accounted for an additional 13% of the variance in PTSD symptoms above and beyond traditional combat, with the combined variables explaining 29% of the variance in PTSD symptoms. Furthermore, the standardized beta weight for killing was about three and a half

times greater than that of traditional combat. We also examined dissociation as an outcome variable and found that after killing was added to the model, traditional combat no longer significantly predicted dissociation, yet killing was strongly related to dissociation. Killing was also significantly associated with alcohol, marijuana, and polysubstance abuse. When examining functional impairment outcomes, killing was associated with greater marital problems, family adjustment, occupational difficulties, and violent behaviors. We present findings related to different types of killing within the war zone and contextualize killing within a larger theoretical framework. Overall, killing is associated with a number of mental health symptoms and functional impairment, even after controlling for traditional combat exposure.

Impact of Line of Duty Killing/Serious Injury in Urban Police Officers

The purpose of this study is to examine the impact of killing or seriously injuring another person in the line of duty among 735 urban police officers. The officers were cross-sectionally surveyed on trauma exposure and mental health symptoms. We conducted a series of hierarchical linear regressions to ascertain the impact of killing/seriously injuring another person over and above other critical incident exposure on PTSD symptoms and depression. Years of service, gender, and personal trauma history were associated with killing/seriously injuring someone and were included in the analysis. 25% of the officers endorsed having to kill or seriously injure someone in the line of duty. This item significantly predicted PTSD and depression symptoms over and above other cumulative critical incident exposure. Impact of killing and causing serious injury was also examined for each PTSD symptom cluster. This item also significantly predicted all three PTSD symptom clusters, over and above other critical incident exposure. This was most dramatic for avoidance symptoms; the standardized beta weight for killing/injury was nearly six times that of other critical incident exposure. Line of duty killing and causing serious injury is an important predictor of mental health symptoms, emphasizing the importance of addressing this in training and subsequent to critical incidents.

The Impact of Taking Another Life in Operation Iraqi Freedom (OIF) Soldiers Returning From Deployment

The purpose of this study is to examine the mental health impact of taking another life among over 3,000 soldiers returning from Operation Iraqi Freedom (OIF). These data were collected as part of a larger study examining mental health outcomes among soldiers returning from deployments to the Middle East. In this study, we controlled for soldiers witnessing killing, and examined the unique contribution of taking another life in combat. Overall, 40% of the sample reported taking another life during their deployment. Even after controlling for witnessing killing, taking another life was a significant predictor of PTSD symptoms, depression symptoms, and alcohol use. Additionally, taking another life in the war zone significantly predicted anger and relationship problems, even after controlling for seeing killing in the Middle East. Similar to findings with police officers and other veterans of war, soldiers currently returning from modern deployments are at risk of mental health symptoms and related functional impairment due to exposure to killing at war. Consequently, mental health treatment of these veterans should include addressing the impact of taking another life in order to optimize readjustment to civilian life following deployment.

Applying Innovative Technologies in Trauma Research and Clinical Practice

(Abstract #196567)

Symposium/Panel (Res Meth, Bio Med) **Salons 7-9, 3rd Floor**

Carlson, Eve, PhD[1]; Woodward, Steven, PhD[2]; Dalenberg, Constance, PhD[3]; Field, Nigel, PhD[4]; Ruzek, Josef, PhD[2]; Spain, David, MD[5]

[1]International Society for Traumatic Stress Studies, Menlo Park, California, USA
[2]National Center for PTSD, Menlo Park, California, USA
[3]Alliant International - San Diego, La Jolla, California, USA
[4]Pacific Graduate School of Psychology, Palo Alto, California, USA
[5]Surgery & Critical Care, Stanford University School of Medicine, Palo Alto, California, USA

Close monitoring of clinical variables can improve clinical research and practice. This symposium will present examples of innovative uses of technology in trauma research and clinical work. The methods allow researchers and clinicians to collect or monitor detailed data in domains of psychological phenomena, sleep, respiration, and heart rate.

Using a Portable, Automated, Electronic Method to Collect Real-Time Data From Trauma Survivors

Ecological Proximal Assessment (EPA) is a portable, automated, electronic, data collection method that allows recording of clinically-relevant symptoms, moods, cognitions, experiences, and behaviors during daily life. The EPA method provides more accurate and detailed monitoring and data collection in trauma survivors because it does not require distressed people to track, summarize, and recall psychological phenomena. Data will be presented data showing some of the unique types of research questions that researchers can use EPA to address, such as what the chronological relationship is between negative posttraumatic cognitions and symp-toms; whether there are differences in patterns of emotional dynamics among those who develop PTSD; whether items assessing PTSD symptom criteria measure the constructs they are intended to measure; and whether there are aspects of early responses to trauma that can predict chronicity of symptoms. Examples will also be provided of how EPA might be useful to clinicians and their clients to track problematic symptoms or behaviors. Information will be provided on how to obtain free specialized PDA software to measure psychological phenomena in research participants or clients and a free manual for the EPA methodology.

Using Mattress Actigraphy to Investigate Aspects of Sleep in PTSD

Laboratory studies of PTSD-related sleep disturbance may have limited validity as evidenced by the low rates of nightmares in that context. Consequently, some researchers in this area have turned to ambulatory monitoring methods such as in-home polysomnography and actigraphy. This presentation will describe mat-tress actigraphy, a zero-burden method that transduces large and small sleeper movements, including respiration and the kinetocardiogram. This allows extended unobtrusive measurements of sleep scheduling, continuity/depth, and accompanying autonomic activation. The data to be presented were obtained from a community-residing sample of participants meeting criteria for PTSD, Panic Disorder, or comorbid PTSD+PD, and from controls. Participants were screened for medical sleep disorders in the laboratory, and thereafter studied at home for an average of 15 nights. PTSD participants were distinguished by extended sleep periods (+ ~50 minutes). PTSD and PTSD+PD participants were characterized by increased rates of muscle twitches during sleep as compared to both PD participants and controls, as well as elevated heart rates (+ ~5 BPM) and reduced respiratory sinus arrhythmia magnitudes (~ -25%). Extended in-home mattress actigraphy suggests that PTSD is paradoxically associated with both pro-longation of sleep and elevated activation/arousal during sleep.

Using Breathing Biofeedback to Enhance Cognitive Behavioral Treatment of Trauma Survivors
Many cognitive-behavioral treatments include breathing retraining or relaxation, but a subset of patients drop out of therapy because they cannot tolerate physiological reactivity. For some, this occurs because they are unable to adequately monitor their physiological symptoms. General guided relaxation protocols in recent years have been augmented by use of inexpensive but accurate biofeedback tools, available for office or client home use. After a brief introduction to heart rate variability analysis, methods of monitoring of heart rate variability will be explained as a more potent form of breathing retraining and affective regulation. Three research projects using biofeedback (a) alone, (b) as a supplement to cognitive therapy with children, and (c) as a supplement to cognitive therapy with adults will be presented.

Interventions Following Terrorism From 3 Months to 5 Years Post-Event

(Abstract #196599)

Symposium/Panel (Disaster, Clin Res) **Grand Ballroom, 4th Floor**

Cloitre, Marylene, PhD[1]; Malta, Loretta, PhD[2]; Levitt, Jill T., PhD[3]; Nacasch, Nitsa, PhD[4]; Foa, Edna B., PhD[5]; Huppert, Jonathan D., PhD[6]; Zohar, Joseph, MD[7]; Fostick, Leah, PhD[8]; Tzur, Dana, MA[7]; Clark, David M., DPH[9]; Gillespie, Kate, MD[10]; Duffy, Michael, PhD[11]; Bolton, David, PhD[10]; Duffy, Michael, PhD[11]; Gillespie, Kate, PhD[10]; Clark, David M., PhD[12]; *Foa, Edna B., PhD*[13]
[1]International Society for Traumatic Stress Studies, New York, New York, USA
[2]Psychiatry, Weill Cornell Medical College, New York, New York, USA
[3]Institute for Trauma and Stress, NYU Child Study Center, New York, New York, USA
[4]Shiba Medical Center, Tel Hashomer, Israel
[5]Department of Psychiatry, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania, USA
[6]University of Jerusalem, Jerusalem, Israel
[7]Department of Psychiatry, Chaim Sheba Medical Center, Tel Hashomer, Israel
[8]The Chaim Shiba Medical Center Israel, Tel Hashomer, Israel
[9]Institute of Psychiatry, Kings College London, London, United Kingdom
[10]Northern Ireland Centre for Trauma and Transformation, Omagh, Ireland
[11]University of Ulster at Magee, Londonderry, Ireland
[12]King's College London, London, United Kingdom
[13]Department of Psychiatry, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania, USA

This symposium will present the results of psychosocial interventions following terrorism from 3 months to 5 years post-event. Type as well as the therapeutic focus of interventions for terrorist-related psychological sequelae, particularly as related to the timing of the intervention post-event, will be discussed.

Community Based Cognitive Therapy for PTSD Following the Omagh and London Bombs in the UK
Controlled trials have shown that trauma focused cognitive behaviour therapies are effective in treating PTSD following non-terrorism related traumatic events. Less is known about the effectiveness of these treatments with terrorism related PTSD. Two studies that focus on this issue are reported. In the first, 91 individuals who developed PTSD following a car bomb in Omagh, Northern Ireland were offered cognitive therapy (CT) based on the Ehlers & Clark (2000) model at an average of 10 months after the event. Assertive outreach was used to identify potential patients. There were no major exclusion criteria. Therapists were national health service staff with modest prior experience with PTSD who received a brief training in CT for PTSD after the bombing. Substantial and significant improvements in PTSD were observed, with pre to post treatment effect sizes (approx 2.2) in line with those reported for CT in trials with non-terrorism related PTSD. The second study is a screen and treat programme that was partly influenced by the Omagh experience and was deployed in London shortly after the July 2005 terrorist bombs. Similar outcomes were observed with 82 patents treated within 18 months of the bombings. Discussion focuses on the lessons learned from both studies.

Treatment of PTSD Linked to Terrorism and Other Civil Conflict in Northern Ireland: A Randomized Controlled Trial
For four decades the community of Northern Ireland experienced a high level of terrorist violence and other civil conflict. Following the apparent success of cognitive therapy (CT) in treating PTSD following the 1998 Omagh car bomb, the Northern Ireland Centre for Trauma and Transformation (NICTT) was established to make the treatment available to victims of other terrorist and conflict related violence over the preceding decades. In the first phase of the NICTTs work, 58 consecutive referrals with PTSD were randomized to either immediate CT or Wait followed by CT. Patients typically had chronic PTSD (median 5.2 years, range 3 months to 32 years) mostly resulting from multiple traumas. Half had failed previous psychological treatments for PTSD. CT was based on the Ehlers and Clark (2000) model and comprised a median of 8 sessions with clinicians allowed flexibility to vary the number of sessions depending on patient need and co-morbidity. There were no improvements during the wait period. In contrast, immediate CT was associated with significant improvement in PTSD, depression and social/work related disability, which was maintained at follow-up. Discussion focuses on the adaptations of CT that were required for a chronic, multiply traumatized population in the context of ongoing threat.

Prolonged Exposure Therapy (PE) Among Patients Suffering From PTSD Due to Terror Attacks in Israel—An Open Study
Frequency and severity of terror attacks in Israel increased substantially during the second Intifadah, starting in September 2000. As a result, a large population of citizens was exposed directly and indirectly to traumatic events. The psychological consequences of such events can be severe, including posttraumatic stress disorder (PTSD). Prolonged Exposure (PE) therapy has been found effective in various types of traumas, with its beneficial results replicated and disseminated into clinical settings. A recent report of the Institute of Medicine (2007) has suggested that the only treatment for PTSD that gained sufficient evidence for its efficacy is exposure therapy. However, evidence for the efficacy of PE for terror victims is scant. In this lecture I will present a study conducted at Sheba Medical Center in Israel examining the efficacy of PE in terror-related PTSD patients; these patients were referred to the psychiatric clinic due to exposure to terrorist attacks such as suicide bombings, explosive devices, or shooting attacks. Patients undergoing PE therapy were evaluated pre and post treatment for their PTSD and depression symptoms, by PhD level independent evaluators. Preliminary results suggest that PE is extremely effective in the treatment of terror-related PTSD. Data on the full sample will be presented.

Resolving PTSD and Rebuilding Psychological and Social Resources for 9/11-Exposed Individuals
A salient consequence of mass violence is the breakdown of social networks and the satisfaction of basic needs, emotional support and sense of `felt membership´ that they provide. In addition, survivors tend to have reduced expectations of support and to be unprepared for the task of rebuilding their networks. We present the results of an open trial (n=59) in which an established multi-component PTSD treatment was adapted to include (1) the rehabilitation of healthy coping and support seeking perceptions and strategies using Skills Training in Affective and Interpersonal Regulation (STAIR) and (2) a modified version of prolonged exposure (PE) to resolve PTSD. The treatment was implemented by therapists who ranged from very to minimally experienced in CBTs. In addition, number of sessions and of session topics were flexible and collaboratively determined by client and therapist. Results indicated reduction in PTSD symptoms equal to that of a benchmarked RCT (ES = 1.79) as well as substantial improvement in day-to-day functioning (.64), hostility (.82), use of alcohol and drugs to cope (.59) negative mood regulation (.70) and use of social support to cope (.43). Given that social support facilitates

recovery from PTSD and protects against its development, intervention and prevention programs incorporating social support interventions should be considered.

Papers
Recent Developments in PTSD Research

Salon 2, 3rd Floor

Chair: Beth Fischer, PhD,
Harlow Center for Biological Psychology, University of Wisconsin, Madison, Wisconsin, USA

A Prospective Examination of Posttraumatic Stress Symptoms From Motor Vehicle Accident to Recovery

(Abstract #196036)

Paper Presentation (Res Meth, Asses Dx)

Fischer, Beth, PhD[1]; Irish, Leah, MA[2]; Kobayashi, Ihori, MA[2]; Spoonster, Eileen, RN[3]; Fallon, William, MD[3]; Delahanty, Doug, PhD[2]
[1]University of Wisconsin, Madison, Wisconsin, USA
[2]Kent State University, Kent, Ohio, USA
[3]Summa Health System, Akron, Ohio, USA

The current PTSD literature is mixed regarding the interrelationship between PTSS, order of symptom presentation, and symptom change over time. The present study examined PTSS, assessed in-hospital, and 6 weeks, 3-, 6-, and 12-months post-mva (n=365). Hierarchical linear modeling was used to systematically track the relationships between PTSS over time. Preliminary analyses suggested that PTSS were highest in frequency and intensity immediately post-mva and gradually decreased over the course of recovery with hyperarousal symptoms demonstrating the slowest rate of improvement over time. Additionally, while hyperarousal was found to be the most prominent predictor of change in intrusion and avoidance over time, change in hyperarousal was also influenced by intrusion and avoidance symptom suggesting a reciprocal relationship. These findings emphasize the significant role of hyperarousal in symptom change and recovery over time, contribute new insight into PTSS theory, and provide insight into pharmacological and clinical treatments that might ameliorate PTSD symptomatology.

Correlates of Acute and Chronic Posttraumatic Stress Disorder

(Abstract #196575)

Paper Presentation (Asses Dx, Clin Res)

Bolton, James, MD[1]; Cox, Brian, PhD[1]; Afifi, Tracie, MSC[1]; Asmundson, Gordon, PhD[2]; Sareen, Jitender, MD[1]
[1]University of Manitoba, Winnipeg, Manitoba, Canada
[2]University of Regina, Regina, Saskatchewan, Canada

Few studies have examined factors that may differentiate acute from chronic posttraumatic stress disorder (PTSD). Clarifying the factors associated with chronic PTSD may direct treatment efforts to prevent a persistent illness course. Data came from the National Comorbidity Survey Replication (NCS-R), a large (N = 5692) nationally representative population survey of adults in the United States. Individuals with PTSD (N = 604) were dichotomized into acute and chronic subgroups based on duration of illness of 2 years. The two groups were then compared across a range of sociodemographic factors and mental disorders. Factor analysis was used to group related traumatic events, and the prevalence of these factors were then compared in persons with acute and chronic PTSD. Chronic PTSD was significantly associated with higher rates of mood and anxiety disorders, as well as higher rates of suicidal ideation and attempts. War and terror-related traumatic events did not distinguish acute from chronic PTSD; the single factor grouping differentiating the two groups was childhood adversity. Individuals with PTSD of greater than two years duration have higher rates of mood and anxiety disorders and suicidal behaviour. Early childhood traumas are potentially more important predictors of chronic PTSD than are combat-related events.

The Impact of Trauma Exposure, Psychiatric Diagnosis, and Resilience on HPA Axis Function

(Abstract #196355)

Paper Presentation (Bio Med, Cul Div)

Weiss, Tamara, MD[1]; Avasthi, Ranjan, MD[2]; Schwartz, Ann, MD[1]; Phifer, Justine,[1]; Bradley, Rebekah, PhD[1]; Ressler, Kerry, MD, PhD[1]
[1]Psychiatry, Emory University, Atlanta, Georgia, USA
[2]Psychiatry, Morehouse University, Atlanta, Georgia, USA

HPA axis dysfunction has been associated with both early life stress and PTSD. This study examined HPA activity as a function of child versus adult trauma history. Data were gathered from 203 participants in a larger study of PTSD in a low SES, urban sample. We found that HPA dynamics varied by exposure to childhood trauma (CT), adult trauma (AT), and childhood plus adult trauma (CT+AT). Trauma history had both independent effects on HPA measures (p=.02) and interaction effects with PTSD (p=.007) and PTSD x MDD (p=.083). Cortisol response to dexamethasone varied as a function of PTSD status in CT+AT participants (but not in CT or AT only participants). We then compared individuals with no history of childhood sexual abuse, early childhood sexual abuse, and late childhood sexual abuse and found that timing of abuse had independent effects on HPA function and interaction effects with MDD and PTSD. HPA dysfunction was more evident in those with early abuse histories. Post-dexamethasone cortisol suppression in non-abused subjects differed significantly from those with early abuse (p=.005) but not late abuse. These data suggest that HPA programming may depend on timing of the trauma. Implications for understanding resilience/risk for trauma-related illness are discussed.

Resource Loss, Personal Values and Distress Among Native Israelis and New Immigrant Terror Victims

(Abstract #196004)

Paper Presentation (Civil Ref, Cul Div)

Fass, Hester, MSW[1]
[1]School of Social Work, Bar Ilan University, Ramat Gan, Israel

Purpose: Since 2000, various terrorist attacks in Israel claimed many lives and wounded thousands, many of them new immigrants. This research aimed to identify the contribution of various factors to the occurrence and severity of PTSD among those wounded in terror attacks. In addition, the consequences of direct exposure to a terrorist attack, following the earlier stressful life-event of immigration, were examined.

Method: Participants included 187 survivors of terrorist attacks, 79 new immigrants and 108 native Israelis. Sociodemographic characteristics, level of exposure, personal values, social support and resource loss were used to predict PTSD occurrence.

Findings: The prevalence of PTSD was 55% among the participants. Resource loss, personal values, level of exposure and social support were identified as predictors of PTSD. Resource loss was identified as the main predictor, but explained significantly higher percentage of the variance among native Israelis than among the new immigrants.

Conclusions: Being wounded in a terrorist attack resulted in persisting PTSD, predicted by various factors. The influence of those factors varied between the native Israelis and the immigrants.

PTSD Treatment Programs: Developing and Implementing Evidence-Based Practice

(Abstract #196140)

Workshop/Case Presentation (Practice, Clin Res) **Salon 1, 3rd Floor**

Phipps, Kelly A., PhD[1]; Chard, Kathleen M., PhD[2]
[1]*Edward Hines Jr. VA Medical Center, Hines, Illinois, USA*
[2]*Cincinnati VA Medical Center, Cincinnati, Ohio, USA*

For over 20 years the VA has offered a full continuum of specialty inpatient and outpatient services for veterans experiencing military-related trauma. These programs vary in their structure, with a range of different types of treatments provided. The VA has recently provided substantial resources toward the dissemination and implementation of evidenced-based treatments. These resources offer an opportunity for change and further development of programming in VA PTSD specialty programs. The purpose of this workshop is to provide clinicians with methods to develop and implement evidence-based programming for both inpatient and outpatient PTSD clinics. The information shared can be applied to any agency that provides residential or day treatment for individuals with a diagnosis of PTSD. Presenters will share their experiences and data regarding the development of a residential PTSD and an outpatient PTSD program utilizing evidence-based treatments. The workshop will include: A brief overview of modalities of treatment for PTSD, Program Design (e.g., needs assessment, components of the program), Program Implementation (e.g., administrative, resources), Program Evaluation, and an interactive group discussion for facilitators and participants to generate strategies to use these methods in their own treatment settings.

Burundian Refugee in the U.S.: Mobilizing Protective Resources

(Abstract #196143)

Workshop/Case Presentation (Civil Ref, Cul Div) **Salon 3, 3rd Floor**

Weine, Stevan, MD[1]; Hakizimana, Leonce, BS[1]; Landgren, Karine, MSC[1]; Gahungu, Athanase, PhD[2]; Ware, Norma, PhD[3]
[1]*University of Illinois at Chicago, Chicago, Illinois, USA*
[2]*Educational Leadership, Curriculum and Foundations, Chicago State University, Chicago, Illinois, USA*
[3]*Social Medicine, Harvard University, Boston, Massachusetts, USA*

Nine thousand Burundian refugees from Tanzanian refugee camps are now being resettled in the U.S. The "1972 Burundians" are mostly Hutu and fled a violent campaign from the Tutsi controlled government. Living in exile in Tanzania for three decades, they experienced ongoing political and criminal violence, sexual assault, poverty, unemployment, dependency, no freedom of movement, family break-up, and poor education. Due to these factors, this refugee group presents important differences from other recent refugees whose resettlement was guided by a conceptualization of refugee trauma that prioritizes recent exposure to political violence (Weine, in press). This workshop applies a preventive mental health model for enhancing protective resources (Weine & Ware, 2007). It identifies community and family protective resources in sociocultural context based upon ethnographic research. Community resources are evident in the churches Burundian refugees quickly joined or formed. Family resources are evident in strong parent-child ties and extended families. Potential interventions for mobilizing protective resources focus on faith-based interventions and parental involvement in education. Presenters will give case examples and encourage discussion involving audience participants that explores approaching Burundian resettlement from a preventive mental health perspective.

A Manualized Group Protocol of Exposure, Cognitive, and Behavioral Treatments for PTSD

(Abstract #196506)

Workshop/Case Presentation (Clin Res, Prev El) **Salons 4-6, 3rd Floor**

Castillo, Diane, PhD[1]; Keane, Terence, PhD[2]; Montgomery, Catherine R., MA[1]
[1]*Behavioral Health Care System (116), New Mexico VA Health Care System, Albuquerque, New Mexico, USA*
[2]*Boston VA Medical Center, Boston, Massachusetts, USA*

The purpose of this workshop is to present a group protocol treatment for PTSD from a recently funded study and will detail how effective therapy interventions—exposure, cognitive, and behavioral—can be provided in structured, small groups. Therapies found most effective for PTSD are exposure and cognitive, with less support for other treatments (Rothbaum, et. al., 2000). Studies have been conducted individually, while most PTSD treatments in VA hospitals are conducted in groups (Garrick, 2000). The literature has shown no difference between specific interventions in groups, including exposure in a group format (Schnurr, et. al., 2003), while support for group exposure was found in a clinical setting (Castillo, 2004). METHODOLOGY: Assessment: pre, post, 3-, and 6-month post treatment; between treatment blocks. Procedure: 72 female OIF/OEF veterans positive for PTSD randomized into a three-person, 16-week treatment group or wait-list control. Blocks: Exposure: trauma and safety nets identifiEd, imaginal exposure. Cognitive: didactic cognitive restructuring, writing of beliefs on safety, trust, power/competence, and esteem/intimacy, distortions examined in session. Behavioral: didactic and videotaped role-play assertiveness training, 4 relaxation techniques. Attendees will gain information on the application of evidence-based treatments for PTSD in a manualized treatment group.

Concurrent Session 3
Thursday, November 13
2:00 p.m. – 3:15 p.m.

Trauma and Reparative Justice
(Abstract #196781)

Featured (Sos Ethic, Media Ed) **Grand Ballroom, 4th Floor**

Danieli, Yael, PhD[1]; Susan, Hirsch, PhD[2]; Mones, Paul, JD[3]; Laperrière, André, MBA[4];
[1]Group Project for Holocaust Survivors and Their Children, New York, New York, USA
[2]Institute for Conflict Analysis and Resolution, George Mason University, Arlington, Virginia, USA
[3]Attorney/Consultant, Portland, Oregon, USA
[4]The Trust Fund for Victims, Sainte-Foy, Quebec, Canada

Delineating the meaning of reparative justice in relation to other forms of justice, and beyond reparation per se, this multidisciplinary panel will convey, from the victims´ and a lawyer´s perspective, their experiences of justice. Missed opportunities and negative experiences in international justice will be examined as a means to better understand critical junctures of trials and victims´ role within the totality of the trial process to demonstrate that, if conducted optimally, the justice process can lead to opportunities for healing. Reparative justice clearly requires ongoing training of all professionals, be it judges, prosecutors, lawyers, interpreters, on all aspects of the courts´ mandates related to victims, including self-care to counteract vicarious victimization.

The First Blueprint for International Mass Casualty Intervention: 5 Principles to Guide Intervention and Research
(Abstract #195863)

Symposium/Panel (Prev El, Disaster) **Wabash Room, 3rd Floor**

Hobfoll, Stevan, PhD[1]; Ursano, Robert, MD[2]; Watson, Patricia, PhD[3]; de Jong, Joop, MD[4]
[1]Psychology, Kent State University & Summa Health System, Kent, Ohio, USA
[2]Psychiatry, Uniformed Services University of the Health Sciences, Kensington, Maryland, USA
[3]National Center for PTSD, Waikoloa, Hawaii, USA
[4]Department of Health, City of Amsterdam, Amsterdam, Holland, Netherlands

The 5 Principles for Mass Casualty Intervention is the first evidence-based consensus supporting recommendations for intervention during the immediate and the mid-term post mass trauma phases. A worldwide panel of experts was assembled on disaster and mass violence study and treatment to extrapolate from related fields of research, and to gain consensus on intervention principles. They identified five empirically supported, intervention principles that should be contained within intervention and prevention efforts. These are promoting: 1. sense of safety, 2. sense of self- and community-efficacy, 3. connectedness, 4. calming, and 5. hope.

The expert panel offers a distilled, comprehensive blueprint of best intervention practices following major disaster and terrorist attack for the short-term and mid-term period ranging from the immediate hours to several months after disaster or attack.

We will apply the 5 Principles of Mass Casualty Intervention to military and civilian settings. We discuss the international transportability of the 5 Principles, which can be translated to Majority World Cultures and Circumstances if cultural-based knowledge is integrated. How the principles can be used to guide public policy will be considered, as well as a standard for judging and evaluating broad intervention efforts.

Participant Alert: Photos relating to mass casualty may be shown.

Brief Eclectic Psychotherapy for PTSD: New Evidence
(Abstract #195987)

Symposium/Panel (Clin Res, Practice) **Salons 4-6, 3rd Floor**

Schnyder, Ulrich, MD[1]; Gersons, Berthold, MD, PhD[2]; Wittmann, Lutz, PhD[3]; Nijdam, Mirjam, MSC[4]; Maercker, Andreas, MD, PhD[5]; Mueller, Julia, PhD[3]; Olff, Miranda, PhD[6]
[1]International Society for Traumatic Stress Studies, Zurich, Switzerland
[2]AMC UVA Dept of Psychiatry, Amsterdam, Netherlands
[3]Department of Psychiatry, University of Zurich, Zurich, Switzerland
[4]Academic Medical Center at the University, Amsterdam, Netherlands
[5]University of Zurich, Zurich, Switzerland
[6]Academic Medical Center, Amsterdam, Netherlands

Brief Eclectic Psychotherapy (BEP) is a multimodal treatment for PTSD comprising five essentials: psychoeducation; imaginal exposure; writing assignments and mementos; domain of meaning and integration; and a farewell ritual. This symposium presents findings from two recent randomized controlled trials testing BEP versus a minimal attention control group, and versus EMDR.

Brief Eclectic Psychotherapy for PTSD; An Introduction
Brief eclectic psychotherapy (BEP) was developed in the eighties when CBT and EMDR were not available as evidence-based treatments for PTSD. Psychodynamic treatments for PTSD then were well received by patients but did not show a reduction of symptoms. BEP has still as the second part of this 16-session protocolized treatment an important emphasis on discussing how the traumatic event(s) has or have changed the view of oneself and of the world around us. This is called the domain of meaning. In terms of CBT this is called "cognitive restructuring" and the objective is to help the patient learn from the event and to stimulate posttraumatic growth. The elements which are responsible for the reduction of symptoms are the psychoeducation for the patients to understand the symptom in relation to the traumatic event. After two RCT's, BEP has been accepted as an evidence-based treatment within the NICE Guidelines in the UK. Similarities and differences of BEP compared to CBT and EMDR will be outlined.

Posttraumatic Growth and PTSD Symptoms in Response to Brief Eclectic Psychotherapy and EMDR
How posttraumatic growth is related to posttraumatic stress pathology is a matter of ongoing debate. Examining these reactions in response to trauma-focused psychotherapy can help us gain more insight into these phenomena. In this paper, preliminary results are presented from a randomized controlled trial comparing Brief Eclectic Psychotherapy (BEP; n = 70) and Eye Movement Desensitization and Reprocessing therapy (EMDR; n = 70). Participants were outpatients who had a diagnosis of PTSD following various kinds of type I trauma. The measures we applied to assess pre-post differences were SI-PTSD, SCID-I/P, IES-R, and PTGI. Preliminary analyses indicate a significant increase in posttraumatic growth and a significant decrease in PTSD symptomatology for both treatment conditions. Relationships between these variables and differences between treatment conditions are discussed.

Brief Eclectic Psychotherapy for PTSD – A Randomized Controlled Trial
Purpose: We conducted a randomized controlled trial of Brief Eclectic Psychotherapy (BEP) versus a minimal attention control group, trying to independently replicate Gersons et al´s findings in a more general trauma population. We applied the seven gold standards outlined by Foa et al. regarding ideal treatment studies of traumatized populations. Primary outcome measure was PTSD symptomatology.
Methods: 39 patients suffering from PTSD following various types of civilian trauma were randomly assigned to either 16 weekly sessions of BEP (n=20) or a minimal attention control group of 16 weeks (n=19). 20 subjects were females, age ranged from 20-74 years. Patients had survived serious accidents (14), violent or sexual assaults (10), childhood trauma (3), war (4), natural

disasters (2), and other traumatic events (6). Patients were assessed pre and post treatment using the SCID, CAPS, and PDS.

Findings: Data collection was only recently finished. A substantial overall reduction of PTSD symptom levels was found. Factors associated with positive outcome will be presented. Conclusions: This is the first RCT of BEP conducted by a research group independent of the center where BEP was originally developed. BEP appears to yield positive results regarding symptom reduction.

Posttraumatic Growth: A Possible Outcome of Brief Eclectic Psychotherapy?
Purpose: Brief Eclectic Psychotherapy (BEP) is designed to not only reduce PTSD symptoms but also to help trauma survivors finding meaning, and discovering a new view of the world and of themselves. In a randomized controlled trial of BEP, we studied posttraumatic growth along with PTSD symptom trajectories over the course of treatment.

Methods: 39 patients suffering from PTSD following various types of civilian trauma were randomly assigned to either 16 weekly sessions of BEP (n=20) or a minimal attention control group of 16 weeks (n=19). 20 subjects were females, age ranged from 20-74 years. Patients had survived serious accidents (14), violent or sexual assaults (10), childhood trauma (3), war (4), natural disasters (2), and other traumatic events (6). Patients were assessed pre and post treatment using the SCID, CAPS, PDS, and the Posttraumatic Growth Inventory (PGI).

Findings: Data collection was only recently finished. PTSD symptom levels decreased, while PGI scores remained stable. The relationship between PTSD symptoms and PG, and other factors associated with PG, will be presented.

Conclusions: BEP does not appear to systematically influence processes of PG. The question of whether the PGI is an adequate outcome measure will be discussed.

Longitudinal Studies Assessing Neurocognitive Functioning in Relation to Trauma

(Abstract #196073)

Symposium/Panel (Bio Med, Clin Res) **State Ballroom, 4th Floor**

Meewisse, Mariel, MSC[1]; Olff, Miranda, PhD[1]; Gersons, Berthold, MD, PhD[1]; Golier, Julia, MD[2]; Vasterling, Jennifer, PhD[3]; Yehuda, Rachel, PhD[4]; Cardenas-Nicolson, Valerie, PhD[5]; Neylan, Thomas, MD[6]

[1]Psychiatry, Academic Medical Center University of Amsterdam, Center for Psychological Trauma, Amsterdam, Netherlands
[2]James J Peters VA Medical Center, Bronx, New York, USA
[3]National Center for PTSD, Veterans Affairs Boston Healthcare System, Boston, Massachusetts, USA
[4]Mount Sinai School of Medicine, Bronx, New York, USA
[5]Department of Radiology, University of California San Francisco, San Francisco, California, USA
[6]University of California San Francisco, San Francisco, California, USA

Neurocognitive impairments in trauma related disorders (i.e. PTSD and depression), are evident. We will present longitudinal data validating PTSD symptoms as risk factor for attentional deficits, support for a relationship between PTSD and cognition over time, showing deployment-related neuropsychological alterations in soldiers, and showing a relationship between brain atrophy rate and rate of neurocognitive decline in PTSD.

PTSD Symptoms in the Early and Intermediate Aftermath of a Disaster Predict Long-Term Attentional Deficits
Previous studies have shown that posttraumatic stress disorder (PTSD) is consistently associated with attentional deficits. However, very little is known about long-term impairing effects of PTSD symptoms on attentional processing. Therefore, we examined the initial and intermediate impact of a major disaster on attentional processing.

In a community-based sample of adults survivors of the Enschede fireworks disaster, PTSD and depressive symptom severity measures were administered at 5 time points, between 2-3 weeks and 4 years postdisaster. We administered the paced auditory serial addition task (PASAT) as a measure for attentional processing at 2 and 4 years postdisaster. PTSD symptoms significantly diminished and PASAT performance improved over time. Multivariate linear regression analysis showed that avoidance symptoms as early as 2-3 weeks postdisaster predicted attentional dysfunction at 2 and 4 years postdisaster. Whereas, at 1,5 years postdisaster severity of reexperiencing symptoms predicted attentional dysfunction 2 and 4 years postdisaster. Thus, depending on the stage postdisaster, particular PTSD symptom clusters indicate which survivors function cognitively less on the long term. Although PTSD symptoms decreased over time, those survivors with early PTSD symptoms do risk falling behind in work or school because of attentional problems years after the disaster.

Longitudinal Brain Assessment of Cognitive Performance in Holocaust Survivors
Background: There is evidence that stress and PTSD may accelerate age-related cognitive decline. to examine the relationship of PTSD to cognition over time we studied Holocaust survivors (n=28) and comparison subjects (n=19) five years after they had undergone a memory assessment which included paired-associate learning and the California Verbal Learning Test (CVLT).

Results: Holocaust survivors with PTSD showed a diminution in PTSD symptom severity as measured by the CAPS ($t = 2.99$, $df = 12$, $p = .011$) but also manifested a decline in paired associates learning (related word pairs: $t = 2.87$, $df = 13$, $p = .013$; unrelated word pairs: $t = 2.06$, $df = 13$, $p = .060$). In contrast, on the CVLT, the Holocaust survivors with PTSD showed improved performance which correlated with symptom improvement; PTSD group differences in the CVLT at follow-up were no longer evident.

Conclusions: The discrepancy in the pattern of performance suggests that aging and clinical state may have an impact on different aspects of memory function affected in PTSD.

Neuropsychological Outcomes of the Iraq War: One-Year Follow-Up of Active Duty Soldiers
Initial findings from the Neurocognition Deployment Health Study (NDHS) indicated that soldiers assessed before deployment and within 90 days of return from Iraq displayed deployment-related neuropsychological alterations. Whether such changes persist over time or remit in the absence of subsequent war-zone exposure remains unknown. To this end, we examined the neuropsychological performances of 164 NDHS cohort members who remained in active duty status 1 year following deployment and who participated in assessments at pre-deployment (Time 1), post-deployment (Time 2), and 1-year follow-up (Time 3). We compared these "early deployers" to 104 cohort members who were also assessed at Time 1 but subsequently deployed between Time 2 and 3 ("late deployers"). Results revealed significant time by group quadratic interactions on measures of verbal ($p=.001$) and visual ($p<.0001$) memory and sustained attention ($p=.009$). The pattern of results suggested partial return to baseline for early deployers during the follow-up period, whereas performance trends were less favorable between Time 2 and 3 (over deployment) in late deployers. PTSD symptoms observed shortly after return from Iraq did not predict neuropsychological performance at 1-year follow-up; however, attentional errors and PTSD symptom severity measured concurrently at 1-year follow-up were positively correlated ($p=.015$).

Longitudinal Brain Atrophy and Neurocognition in PTSD
Our purpose was to understand the relationship between brain atrophy rate and rate of neurocognitive decline, using voxel-wise morphometric methods. Brain magnetic resonance imaging, clinical, and neuropsychological evaluations were conducted on 28 PTSD+ (CAPS: 60 „b 17, 50 „b 6 yrs) and 25 PTSD- (CAPS: 4 „b 5, 52 „b 6 yrs) patients; testing was repeated after 2.8 „b 0.6 yrs. Maps of longitudinal brain change in standard space were created using nonlinear registration methods. These maps were dependent variables in linear regression models that explored the location

and extent of anatomical variation related to independent variables such as PTSD severity or change scores on verbal, visual, and working memory measures. We observed that longitudinal brain change in the frontal and anterior temporal cortex was related to change in CAPS score; tissue recovery was observed in patients with decreasing PTSD severity and greater tissue loss in patients with increasing PTSD severity. Verbal memory decline was related to greater atrophy rate in the region surrounding posterior cingulate, and visual memory decline was related to posterior temporal and parietal white matter regions. In conclusion, different patterns of longitudinal brain change underlie the clinical and cognitive changes observed in PTSD over time.

Symptom Clusters, Comorbidities, Provider Detection, and Preference-Weighted Health Status of PTSD

(Abstract #196103)

Symposium/Panel (Practice, Asses Dx) **Adams Ballroom, 6th Floor**

Freed, Michael C., PhD., EMT-B[1]; Yeager, Derik E., MBS[2]; Magruder, Kathryn M., MPH, PhD[2]; Liu, Xian, PhD[3]; Gore, Kristie L., PhD[1]; Engel, Charles C., MD, MPH[1]

[1]Deployment Health Clinical Center / Department of Psychiatry, Walter Reed Army Medical Center / Uniformed Services University of the Health Sciences, Washington, District of Columbia, USA
[2]Department of Psychiatry and Behavioral Sciences, Ralph H. Johnson VA Medical Center / Medical University of South Carolina, Charleston, South Carolina, USA
[3]Deployment Health Clinical Center / Walter Reed Army Medical Center, Walter Reed Army Medical Center / Uniformed Services University of the Health Sciences, Washington, District of Columbia, USA

In this symposium, we examine PTSD symptom criterion clusters in veterans and how the predominance of these clusters in patients relates to 1) medical and psychiatric morbidity; 2) patient factors that influence provider recognition of PTSD; 3) preference-weighted heath status.

Is There a Link Between PTSD Symptom Clusters and Medical and Psychiatric Morbidity?
Based on primary care rosters from four Southeastern VAMCs, a total of 1076 randomly sampled primary care patients were administered the PCL and queried about socio-demographic information. These data were merged with ICD9 diagnoses from the VISN7 corporate database. Complete data were available for 879 patients. The 17 *DSM-IV* symptoms from the PCL were grouped into three clusters (*DSM-IV* criteria B, C, and D). PCL scores were then summed, within each cluster, and divided by the total PCL score. Tertiles were assigned based on the distribution of scores within each cluster. ICD9 codes were aggregated and collapsed into medical and psychiatric diagnoses. In general, men were more likely to endorse a higher proportion of B and D cluster symptoms and women a higher proportion of cluster C. Symptom endorsement was otherwise evenly distributed by age and race. of the major medical diagnoses examined, only hypertension demonstrated a predominant association with one symptom cluster, cluster D. This suggests that patients endorsing the highest tertile of D cluster symptoms were about 2.4 times more likely to have hypertension than patients in the lowest tertile, controlling for clusters B and C. Individual symptom clusters were not singly associated with any psychiatric comorbidity.

Are PTSD Symptom Patterns Related to Primary Care Provider (PCP) Diagnosis of PTSD?
This presentation examines the impact of PTSD symptom patterns on primary care provider (PCP) recognition of PTSD. Based on a random sample of primary care VA patients from 4 hospitals, we assessed PTSD with the CAPS and PCL; we also collected socio-demographics, functional status, and medical record diagnoses for both psychiatric and medical illnesses. Complete/usable data were available for 819 patients, of whom 98 (12%) met criteria for PTSD. Of these, 42 (43%) were correctly diagnosed by their PCP. PCL responses were grouped into symptom clusters corresponding to *DSM-IV*-TR B, C, and D criteria, and the clusters were tertiled. After adjustment for age, gender, race, and warzone service, analyses showed that patients in the upper two tertiles for both criteria B (reexperiencing) and D (increased arousal) were more apt to have been recognized than patients in the lowest tertiles. Thus, providers tend to identify the more classical symptoms of PTSD.Given the high rates (>50%) of non-detection of PTSD in primary care, screening instruments and provider education may be helpful strategies to improve detection of atypical presentations of PTSD.

Preference-Weighted Health Status in Veterans With PTSD
Unlike symptom severity and generic quality of life measures, preference-based outcomes are useful for policy and medical decision making because they include assessments of "value" or "worth" of disease states like PTSD. Preference-weighted health status (PWHS) is measured on a scale between anchors of death (equal to 0) and perfect health (equal to 1). We present the relative contributions to decrements in veteran PWHS from demographic variables, PTSD diagnosis and severity, and the co-occurrence of other mental health disorders. We developed a regression model to predict PWHS from a random primary care sample 811 veterans (11.5% diagnosed with PTSD). Responses from the PTSD checklist, Clinician Administered PTSD Scale, Mini International Neuropsychiatric Interview, and Medical Outcomes Survey Short Form-36 (SF-36) were used along with previously published preference-weights for SF-36 defined health states. The model predictors accounted for 38% of PWHS variance, with a PTSD diagnosis reducing PWHS by 0.08 (95%CI of the regression coefficient: 0.02, 0.14). PTSD severity, co-occurring mental health disorders, and demographic variables also significantly contribute to PWHS. This is the first study to present PWHS in persons with PTSD. PWHS in this study can be helpful for future cost-effectiveness studies of PTSD treatments.

Co-Occurring Partner Violence and Mental Health: Novel Settings for Identification and Treatment

(Abstract #196157)

Symposium/Panel (Clin Res, Asses Dx) **Salons 7-9, 3rd Floor**

Talbot, Nancy, PhD[1]; Bryant-Davis, Thema, PhD[3]; Chaudron, Linda, MD, MS[1]; Cerulli, Catherine, JD, PhD[1]; *Krupnick, Janice, PhD*[2]

[1]Department of Psychiatry, University of Rochester School of Medicine and Dentistry, Rochester, New York, USA
[2]Department of Psychiatry, Georgetown University, Washington, District of Columbia, USA
[3]Graduate School of Education and Psychology, Pepperdine University, Valley Village, California, USA

Intimate partner violence (IPV) is under-reported by women in community settings and concurrent mental health burdens are undertreated. This symposium features mental health interventions in real-world settings with women affected by IPV. Intervention results from a pediatric clinic, family court, and community mental health center will be shared.

Psycho-Social Risk Factors, Intimate Partner Abuse, and African American Women
When examining the experiences of diverse women, researchers find that African American women are among those at greater risk of partner abuse. The purpose of this study was to explore psycho-social factors that may influence intimate partner abuse experiences of African American women. This study is based on a national sample of African American mothers in The Fragile Families and Child Wellbeing Study, which is a study based on a cohort of 4,898 women who gave birth in 20 large U.S. cities. 44% of the sample is African American. The measure which was utilized is the interview questionnaire from the Fragile Families Project. A series of cross-tabular analyses were used to assess whether partner abuse was predicted by the previously listed psycho-social factors. Chi-square statistics were used to determine significance of crosstab results. The findings indicate that living in

unsafe, impoverished neighborhoods, older age, and endorsement of traditional gender roles are related to higher instances of partner abuse of African American mothers. This project advances the literature by illuminating the influences of psycho-social risk factors in the lives of African American women. This project was funded by the Robert Wood Johnson Foundation´s New Connections Initiative.

Evidence-Based Depression Treatment in Community Care: IPT for Women With Trauma Histories
In community mental health settings depressed women with interpersonal trauma histories are a large segment of the patient population. Yet evidence-based therapies for depression are rarely studied in community settings with women in violent relationships, who experienced childhood abuse, and have high psychiatric and socioeconomic burden. Interpersonal Psychotherapy (IPT) is an evidence-based depression treatment we are examining among women in a community mental health center (CMHC) who have major depression and sexual abuse histories. The majority also suffer chronic depression, PTSD, and intimate partner violence. Findings from two treatment studies in a CMHC will be presented: an uncontrolled pilot study of modified IPT (n=36) and a randomized trial of modified IPT compared to usual care (n=70). Participants were predominantly low-income, minority-group members, and single mothers. In the pilot study we found that women experienced a decline in depressive symptoms and improved mental-health functioning but did not significantly improve in overall social functioning. Results from the randomized controlled trial will be presented. We will address how comorbid PTSD and intimate partner violence affected women´s ability to engage in treatment and their treatment outcomes. Modifications to IPT that may assist its transport to community mental health care will be discussed.

Exploring the Overlap of Intimate Partner Violence and Perinatal Depression
Perinatal depression affects 10-20% of new mothers and up to half of low-income mothers. Intimate partner violence (IPV) affects 15% of pregnant women with the rates among postpartum women essentially unknown. Both depression and IPV are under-reported by women, poorly detected by providers, and their relationship is not yet established. Our study examined IPV prevalence in a sample of low-income mothers attending infant well-childcare visits. Women (n=198) attending an urban pediatric clinic in the postpartum year completed a standardized psychiatric interview and a series of questionnaires, including a self-report of IPV over their lifetime, during pregnancy, and in the postpartum period. We examined associations between depression and IPV. Preliminary results revealed that 28% of participants reported IPV threats or assaults. Of those reporting IPV, 40% reported events during pregnancy and 13% reported events in the first postpartum month. Injuries ranged from minor cuts and bruises to broken bones and organ damage. Women who reported threats of physical harm by intimate partners had significantly more depressive symptoms than those who did not endorse threats. Implications for IPV assessment and interventions in pediatric settings will be discussed.

Linking Court-Based Intimate Partner Victims With Mental Health Services: Will They Connect?
Many studies document high correlations between intimate partner violence (IPV) and mental health burden, yet few studies have been able to make causal connections or determine temporal ordering of violence and mental health symptoms. The current study assessed mental health symptoms among IPV victims filing for protection orders and reassessed symptoms 1 week and 6 months post-court appearance. We examined whether the issuance or denial of protection orders mediated women´s subsequent depression. We will also report on a randomized controlled trial in the court that linked IPV victims to mental health services. A sample of 190 women, average age 32 years, half minority-group members, were randomized to one of three referral groups: standardized pamphlet for mental health services, an individualized assessment and printed referral, or an individual assessment and printed referral coupled with a brief patient engagement. Women´s mental health service use at 6 months post-intervention will be reported. Finally, the implications for court-based mental health interventions for women involved in IPV will be explored.

Participant Alert: The content of the presentations in this symposium addresses violence against women and children and may be distressing for some people.

Measuring Fidelity in Treatment Implementation: Validity vs. Practicality

(Abstract #196254)

Symposium/Panel (Clin Res, Practice) **Monroe Ballroom, 6th Floor**

Hanson, Rochelle, PhD[1]; Saunders, Benjamin, PhD[1]; Ruggiero, Kenneth, PhD[1]; Kolko, David, PhD[2]; Amy, Herschell, PhD[3]; *Berliner, Lucy, MSW*[4]
[1]*Medical University of South Carolina, Charleston, South Carolina, USA*
[2]*University of Pittsburgh, Pittsburgh, Pennsylvania, USA*
[3]*Western Psychiatric Institute and Clinic, Pittsburgh, Pennsylvania, USA*
[4]*University of Washington, Seattle, Washington, USA*

This presentation will describe common fidelity measurement approaches used in efficacy studies, effectiveness studies, and implementation projects, measurement validity issues associated with each approach, and the costs and logistics of using them in comunity service agencies. Two NIMH-funded studies will be presented, highlighting different methods of assessing clinician fidelity to evidence-supported trauma-focused treatment interventions as well as the challenges inherent in conducting this type of research.

Fidelity in Treatment Implementation: Overview
A crucial issue when attempting to implement evidence supported trauma treatments in community service settings is how to measure therapist fidelity to the treatment model in a scientifically valid yet practical manner, given the realities of front-line agency practice. Scientific validity arguments suggest that therapist fidelity to a treatment model can only be measured through relatively complex methods such as live monitoring and rating of actual sessions by treatment experts or by taping of sessions and coding by trained observers. Unfortunately, the costs of using these measurement methods in terms of effort, expertise, money, and staff time may be well beyond the capacity of implementing service organizations. However, easier and less costly approaches such as therapist self-report or a client completed treatment module checklist are considered far less accurate. This presentation will describe common fidelity measurement approaches used in efficacy studies, effectiveness studies, and implementation projects, measurement validity issues associated with each approach, and the costs and logistics of using them in community service agencies. Balancing the issues of validity and practicality in fidelity measurement in implementation projects will be discussed.

Assessing Treatment Fidelity in Trauma-Focused Treatment With Children
Investigation of the dissemination and effectiveness of evidence-based interventions is an important, but challenging area of research. We are conducting an ongoing NIMH-funded study (PI: Rochelle F. Hanson) to examine transport of an evidence-based treatment to community-based settings as a function of two different training modalities (i.e., workshop versus supervision). The "BRidGE" project (Bridging the Research Gap Effectively) utilizes a single subject multiple baseline design, with community-based clinicians, to measure fidelity to a protocol with demonstrated efficacy in the treatment of violence-exposed youth: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006). The primary measure of clinician fidelity is coded audiotapes of treatment sessions. Clinicians (n=17) also completed a self-report measure about their use of TF-CBT components in their treatment sessions over the prior four months. We have coded audiotapes of treatment sessions and

completed self-report questionnaires for seven of these clinicians. In this paper, we will present data examining associations between clinicians´ self-reported use of TF-CBT components as measured by the self-report measure, compared to the coded audiotapes of treatment sessions. The paper will conclude with recommendations for future work in this important and challenging line of research.

Fidelity in the Field: Adherence to AF-CBT in an Effectiveness Trial
The Partnerships for Families project is an NIMH-funded study designed to evaluate the effectiveness of Abuse-Focused Cognitive Behavioral Therapy (AF-CBT), an evidence-based treatment for child physical abuse. Counselors from 10 community agencies have been randomized to AF-CBT or Treatment or Usual. Participating practitioners can enroll families they are treating who have a caregiver experiencing or who is at risk for experiencing difficulties with the use of physical discipline. AF-CBT practitioners receive 32 hours of workshop training and 20 hours of case consultation over 6 months. We describe in this presentation our initial efforts to describe, measure, and enhance adherence to AF-CBT. This will include a description of our samples and data collection methods, the scales developed for rating AF-CBT use, and several issues that were addressed in the construction of these scales. We will report data based on the training (% agreement = .78 – 1.00; M = ,87) and implementation phases including correlates of high adherence. Issues of relevance to the field, such as coder training and preparation, the need for ongoing quality control checks, and the use of feedback for practitioners, will be discussed. Based on this initial experience, specific recommendations for research and practice will be reviewed.

Papers
Novel Interventions for PTSD

Salon 1, 3rd Floor

Chair: Ronald Murphy, PhD,
International Society for Traumatic Stress Studies, Florence, South Carolina, USA

PTSD: Is the Internet of Any Use?

(Abstract #196273)

Paper Presentation (Media Ed, Res Meth)

Herbert, Christophe, MA[1]; Brunet, Alain, PhD[2]
[1]Psychiatry, Douglas Hospital Research Centre, Montréal, Québec, Canada
[2]Psychiatry, McGill university, Montréal, Québec, Canada

In 2006, 113 millions Americans searched the Internet for health-related information and 22% of them searched specifically for information on mental health (Fox, 2006). The goal of the present study was to understand, classify and offer prototypical examples of the type of applications that can be found currently on the internet with respect to PTSD. We conducted a thorough web and literature review with keywords like «Internet», «Web», «PTSD» and «trauma» using the Pubmed, PsycInfo and PILOTS databases. 1. Most typically the sites provide basic information on the disorder for the general public or for trauma survivors. 2. Internet can also provide a way for victims to express themselves about their feelings (blogs, chat, ...). 3. Other sites propose an on-line `diagnostic´ tool which can serve a useful triage function and lead to referral. 3. The effectiveness of on-line secondary and tertiary prevention intervention (i.e. debriefing-like interventions and psychotherapy) has also been examined in a number of RCTs. 4. Some organizations are also using the internet to develop e-learning programmes for their students or for professionals. 5. Recent papers also report on the use of internet to conduct trauma research. The benefits and limitations of those applications will be discussed and future directions will be outlined.

Development and Pilot-Test of a Group Intervention for Traumatized Homeless Women

(Abstract #196179)

Paper Presentation (Clin Res, Commun)

Rayburn, Nadine, PhD[1]; Gilbert, Mary Lou, MA, JD[1]; Wenzel, Suzanne, PhD[1]; Jaycox, Lisa, PhD[2]; Golinelli, Daniela, PhD[1]
[1]RAND Corporation, Santa Monica, California, USA
[2]RAND Corporation, Arlington, Virginia, USA

Homeless women experience high levels of trauma and posttraumatic stress disorder (PTSD). Although successful cognitive-behavioral interventions for PTSD exist, none specifically address the needs of homeless women. This paper describes a multi-phase study that tailored cognitive-behavioral treatment components for PTSD to the needs of homeless women. Throughout the development of our group intervention we conducted focus groups to obtain input from homeless women living in shelters and from providers of services to homeless women. Our goal was to maximize the relevance of the cognitive-behavioral group treatment and minimize the barriers to access.

The final phase of the study consists of a pilot test of the intervention with homeless women who have subthreshold PTSD. 32 women are randomly assigned to either the PTSD intervention condition or to an assessment-only waitlist control condition. We assess changes in PTSD and depression symptoms as a function of participation in the intervention. This presentation summarizes data from our focus groups collected during the development of the treatment, as well as outcome data from our pilot study.

Treating PTSD With a Time-Limited Psychodynamic Approach: Manual Development and Efficacy Data

(Abstract #196222)

Paper Presentation (Clin Res, Child)

Shafran, Naama, MA[1]; Rosenbach, Lea, MA[2]; Wolff, Maya, PhD[3]; Harish-Avidan, Shelly, MA[3]; Foa, Edna, PhD[4]; Gilboa-Shechtman, Eva, PhD[5]
[1]Psychology, Bar Ilan University, Jerusalem, Israel
[2]Psychology, Student Counseling Center, Ramat Gan, Israel
[3]Psychology, Bar Ilan University, Ramat Gan, Israel
[4]University of Pennsylvania, Philadelphia, Pennsylvania, USA
[5]Psychology; The Gonda Multidisciplinary Brain Research Center, Bar Ilan University, Ramat Gan, Israel

Time-limited psychodynamic therapy (TLDP) principles are often used as a prism through which themes from the patient's life are formulated into a central therapeutic issue. to date, there are no disorder-specific manuals based on this approach. We developed a TLDP manual for treating adolescent victims of single event traumas suffering from PTSD based on the work of James Mann (1973) and Lester Luborsky (1984). This manual includes 21 sessions: 3 initial sessions of central issue formulation and 18 "working through" sessions. The central issue focuses on an unresolved conflict, the patient's negative self-image and associated emotions. It is formulated to account for the impact of trauma. The working-through sessions are developmentally adjusted to enhance adolescents' involvement in treatment. Nineteen adolescents (13 girls, ages 11-17, mean 13.8 years), victims of a single traumatic event (e.g., terror, sexual and physical assaults) began treatment according to this manual. Based on self report measures, the effect size of completers (N=15) was 1.02 for Posttraumatic, 1.08 for depressive and 1.49 for general anxiety symptoms. A TLDP manual can be effective in reducing emotional distress among adolescent PTSD sufferers. Implications for the understanding of the mechanisms of therapeutic change, and psychological vulnerability underlying PTSD, are discussed.

Effect of a Motivation Intervention on Treatment Engagement Process Variables Among PTSD Veterans

(Abstract #196327)

Paper Presentation (Clin Res, Mil Emer)

Murphy, Ronald, PhD[1]; Thompson, Karin, PhD[2]; Murray, Marsheena, BA[3]; Quaneecia, Rainey, BA[4]; Uddo, Madeline, PhD[5]
[1]*International Society for Traumatic Stress Studies, Florence, South Carolina, USA*
[2]*Memphis VA Medical Center, Memphis, Tennessee, USA*
[3]*Kent State University, Kent, Ohio, USA*
[4]*Washington State University- Pullman, Pullman, Washington, USA*
[5]*Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana, USA*

This presentation describes early results from a randomized trial of the PTSD Motivation Enhancement (PME) Group, designed to increase problem recognition and treatment engagement among combat veterans. Previously presented findings show superior attendance in outpatient PTSD treatment for PME Group participants compared to controls. Presented here are findings regarding predicted differences on process variables. Combat veteran participants were randomly assigned to either four sessions of the PME Group (n=60) or psychoeducation (PE Control, n=54) in the second month of a 12-month VA outpatient PTSD program. A number of treatment engagement variables were assessed at the end of participants´ attendance at the PME Group or control group condition. Significant t-tests and other analyses indicated that compared to controls, PME Group participants more often decided that problems previously identified as "Might Have" were definitely a problem, were higher on Task and Bond subscales of the Working Alliance Inventory for, and were more satisfied with, their just-completed group, gave higher ratings of overall treatment relevance, and gave higher ratings of endorsement for some items of responsibility-taking for addressing problems. Limitations and implications for PTSD treatment engagement and motivation interventions are discussed.

Papers

PTSD and Conflict-Affected Children

Crystal Room, 3rd Floor

Chair: Wietse Tol, MA,
Public Health & Research, HealthNet TPO, Amsterdam, Netherlands

School-Based Intervention for War-Affected Children: Randomized Trials in Burundi and Indonesia

(Abstract #196256)

Paper Presentation (Clin Res, Civil Ref)

Tol, Wietse, MA[1]; Komproe, Ivan, PhD[1]; Susanty, Dessy, MA[2]; Ndayisaba, Aline, MA[3]; de Jong, Joop, PhD[4]
[1]*Public Health & Research, HealthNet TPO, Amsterdam, Netherlands*
[2]*CWS Indonesia, Jakarta, Indonesia*
[3]*TPO Burundi, Bujumbura, Burundi*
[4]*VU University Amsterdam, Amsterdam, Netherlands*

The evidence base of mental health treatments for people exposed to complex emergencies in low- and middle income countries is weak (Patel et al, 2007). We aimed to evaluate treatment outcome of a school-based psychosocial intervention in civil war-affected northern Burundi and communal violence-affected Central Sulawesi, Indonesia.

Children, in randomly selected schools, were screened with symptom checklists for posttraumatic stress symptoms, anxiety and depression and subsequently enrolled in a treatment (Burundi n=153, Indonesia n=182) or waitlist condition (Burundi n=176, Indonesia n=221). Child and parent assessments with contextually adapted standardized instrumentation, including symptomatology, resilience variables, and functioning, took place before, right after, and 6 months after treatment. Treatment consisted of the manualized 15-session Classroom-based Intervention (CBI; Macy et al, 2003), which emphasizes integrating cognitive-behavioral techniques with cooperative play and creative-expressive exercises.

Intent-to-treat analyses revealed significantly larger gains of moderate effect sizes 6 months after treatment on PTSD (Cohen d=.44) and Hope (Cohen d=.38) in Indonesia, but similar gains over time in the treatment and waitlist conditions in Burundi. The presentation will address the research and treatment implications of these findings.

Participant Alert: Presentation will refer to war events children were exposed to and their consequences for mental health.

Use of Subjective Measures in the Assessment of Terrorism Among Children in Southern Darfur

(Abstract #196497)

Paper Presentation (Child, Asses Dx)

Morgos, Dorothy, PhD[1]
[1]*Yale School of Medicine, New Haven, Connecticut, USA*

The use of children's drawings and narratives aimed at addressing the effects of terrorism remain scarce in the literature, particularly on the African continent. Baseline assessment was conducted to determine the prevalence of psychological distress among a randomly selected sample of 331 children ages 6-17 living in three IDP camps. The children were interviewed in Arabic using: Demographic profile, War Events Inventory, Child Posttraumatic Stress Reaction Index, Child Depression Inventory, Expanded Grief Inventory, Children´s drawings and Trauma narratives. The majority of participants were exposed to high levels of war related violence, with no significant differences for the types of war exposure. total of 75% of the children met the *DSM-IV* criteria for PTSD, while 38% exhibited symptoms of clinical depression, and 20% reported grief reactions. Results from children´s drawings and trauma narratives provided implications for future assessment and interventions. Importance of incorporating subjective measures and translation of cultural and age differences in expressing traumatic reactions to terrorism are discussed in terms of providing culturally sensitive assessments and interventions without compromising the empirical integrity. The ethical and empirical challenges of using subjective measures in the assessment of terrorism are discussed.

State By State Partnership in Support of Returning Combat Veterans and Their Families

(Abstract #196034)

Workshop/Case Presentation (Commun, Prev El) **Salon 3, 3rd Floor**

Straits-Troster, Kristy, PhD[1]; Kudler, Harold, MD[1]; Goodale, Bob, MBA[2]; Oliver, John, DMIN[3]
[1]*Dept. of Psychiatry & Behavioral Sciences, Durham VAMC & Duke University, Durham, North Carolina, USA*
[2]*Citizen Soldiers Support Program, UNC-Chapel Hill, Chapel Hill, North Carolina, USA*
[3]*Chief, Chaplain Service, Durham VAMC, Durham, North Carolina, USA*

This interactive workshop will demonstrate the need for community collaboration in supporting returning combat veterans and their families and will provide specific examples of successful innovations and partnerships. In the United States, the state is the ideal functional unit for post deployment community intervention. We will provide a template for partnering with leadership at the state level, including: National Guard, Department of Defense

(DoD), Department of Veterans Affairs (VA), state and community mental health and substance abuse services, state veterans service officers, clergy/chaplains, employers, educational systems and veterans service organizations. Specific examples include: 1) State summit meetings; 2) New dissemination channels for outreach and knowledge management; 3) Expedited access to care in rural communities through targeted primary care provider support and training for child and family therapists; and 4) Community clergy training through clinical pastoral education networks. Participants are encouraged to share their local successes and challenges and to consider new ways to partner across communities.

Creating a Trauma-Informed Child Welfare System: The Child Welfare Trauma Training Toolkit

(Abstract #196162)

Workshop/Case Presentation (Media Ed, Child) **Salon 2, 3rd Floor**

Ko, Susan, PhD[1]; Sprague, Caryll, MA[1]; Conradi, Lisa, PsyD[2]; Wilson, Charles, MSW[3]

[1]UCLA Neuropsychiatric Institute and Hospital, National Center for Child Traumatic Stress, Los Angeles, California, USA
[2]Chadwick Center for Children and Families, San Diego, California, USA
[3]Rady Children's Hospital, San Diego, Chadwick Center for Children and Families, San Diego, California, USA

In a given year, perhaps one million children come to the attention of the child welfare system. Many are victims of abuse or neglect, live with caregivers who are impaired, and deal with school and community violence as a fact of life. Increasing knowledge and building skills among caseworkers and other child welfare personnel is critical to identifying and providing early intervention for children traumatized by maltreatment and other stressors. The Child Welfare Trauma Training toolkit was developed by the National Child Traumatic Stress Network and partners and the purpose is to provide training for public child welfare professionals that enhances their understanding of the impact of trauma on the development and behavior of children. The training is designed to build knowledge about when and how to assess for trauma, intervene directly in a trauma-sensitive manner, and provide strategic referrals for evidence-based services. The toolkit has been created as a train-the-trainer manual and includes the Trainer´s Guide, Slide Kit, Supplemental Handouts (e.g., vignettes, Child Welfare Trauma Referral tool), audioclip, and the Comprehensive Guide. The workshop will walk particiants through the entire manual and highlight tips for how to effectively use the activities in the manual during a training (e.g., vignettes, videos, evaluation tools).

Concurrent Session 4
Thursday, November 13
3:30 p.m. – 4:45 p.m.

Cognitive Therapy for Posttraumatic Stress Disorder

(Abstract #197588)

Master (Practice, Clin Res) **Monroe Ballroom, 6th Floor**

Clark, David, DPHIL[1]

[1]Institute of Psychiatry, King's College London, London, United Kingdom

Ehlers and Clark (2000) proposed a cognitive model of the development and maintenance of PTSD that specifies three main therapeutic targets. These are: 1) reducing re-experiencing by elaborating the trauma memory and discriminating between current triggers and cues that were present at the time of the Trauma, 2) identifying and modifying excessively negative appraisals of the trauma and/or its sequelae; and 3) dropping problematic maintaining cognitive and behavioural strategies. A novel cognitive therapy (CT) programme that specifically focuses on these targets was developed and tested in four randomized controlled trials and two dissemination studies. Taken together these studies show that the treatment is: acceptable to patients (low drop-out rate), effective (large controlled effect sizes relative to no-treatment), and specific (superior to an alternative, equally credible psychosocial treatment). The trials have established the treatment´s efficacy for PTSD following single and multiple traumatic events in adulthood including those arising from civil conflict and terrorism. The dissemination studies have shown that the treatment can be transported to everyday community clinical settings without loss of effectiveness. Finally, an intensive version of the treatment that concentrates the therapeutic work into a single week has been developed and shown to be similarly effective.

This presentation describes and illustrates the key therapeutic manoeuvres in CT for PTSD. The overall treatment programme includes elements that are common in other empirically validated CBT programmes (e.g. imaginal reliving and cognitive restructuring) as well as novel features. The presentation concentrates on the more novel features, which are illustrated with video tapes of live treatment sessions. Key manoeuvres include: 1) identifying triggers for intrusive memories and discriminating between these triggers and the original trauma using experiential work; 2) working on linking trauma hot spots with updating information and facilitating elaboration; 3) re-scripting intrusive images; and 4) dealing with a wide range of problematic behavioural and cognitive strategies.

Participant Alert: Video tapes of treatment sessions in which patients exhibit distress will be shown.

SOLDIERS OF CONSCIENCE: Award-Winning Documentary About Killing in War (PBS Broadcast – Oct 2008)

(Abstract #196644)

Media Presentation **Crystal Room, 3rd Floor**

Weimberg, Gary, BA[1]; Ryan, Catherine, MA[1]; *Maguen, Shira, PhD*[2]

[1]SOLDIERS OF CONSCIENCE, Luna Productions, Berkeley, California, USA
[2]PTSD Program (116P), San Francisco VA Medical Center, San Francisco, California, USA

This presentation introduces SOLDIERS OF CONSCIENCE as a media resource for trauma specialists, social workers, and clergy serving soldiers, veterans, and their families. SOLDIERS OF CONSCIENCE operates with a central premise: every soldier is a soldier of conscience. Told entirely by soldiers, this documentary film reveals that the act of killing another human being is one of

the most traumatic experiences in life. Be they sincere war fighters or sincere conscientious objectors, all soldiers must face this burden of conscience – and the serious moral and psychological consequences it may entail. Made with an official assistance agreement from the US Army, SOLDIERS OF CONSCIENCE is an intimate, personal and honest film about killing in war and its impact on the young men and women who serve our nation. The filmmaker will screen an extended excerpt and participate in discussion about issues raised by the film, as well as potential uses in clinical, counseling, and faith settings. Such uses include screening the film as:

- a professional development tool for mental health staff
- a counseling resource for families of soldiers and veterans
- a therapeutic resource (where appropriate) for veterans dealing with PTSD, depression, or other issues, and
- a community resource for congregations seeking to support veterans and their families.

Participant Alert: SOLDIERS OF CONSCIENCE depicts brief, but graphic images of war, including: dead and injured human bodies, gunfire and loud explosions.

Not to Forget Culture—Studies on the Development and Maintenance of PTSD

(Abstract #195872)

Symposium/Panel (Cul Div, Res Meth) **State Ballroom, 4th Floor**

Maercker, Andreas, MD, PhD[1]; Norris, Fran, PhD[2]; Hinton, Devon, MD[3]; de Jong, Joop, MD[4]; *Hobfoll, Stevan, PhD[5]*
[1]Psychopathology and Clinical Intervention, University of Zurich, Zurich, Switzerland
[2]Dartmouth College, White River Junction, Vermont, USA
[3]Harvard University, Cambridge, Massachusetts, USA
[4]Vrije Universiteit Amsterdam, Boston University School of Medicine, Amsterdam, The Netherlands, Netherlands
[5]Kent State University, Kent, Ohio, USA

Research on the etiology of PTSD has identified several biopsychosocial factors that contribute to its development and maintenance. Among the variables that have only rarely been investigated are cultural factors. Studies using samples from different cultures living in their home countries (China, Germany) or as immigrants to the US (Vietnamese, Cambodians) are presented.

PTSD in the Vietnamese Community Following Hurricane Katrina
One year after Hurricane Katrina devastated New Orleans, we assessed 82 members of the Vietnamese community who had participated in a larger study of immigration weeks before the disaster struck. PTSD was assessed with the Vietnamese version of the Composite International Diagnostic Interview for *DSM-IV*, the same measure that was used in the National Latino and Asian American Study (NLAAS), conducted in the United States. Despite high trauma and loss, only 5% of the sample met all criteria for PTSD related to Hurricane Katrina, but 21% met criteria for partial PTSD. Avoidance/numbing symptoms did not form a coherent cluster and were seldom confirmed, but intrusion, arousal, and interference were common. Sex, age, education, severity of exposure to the flood waters, property loss, and subjective trauma were independently related to PTSD symptoms. Katrina-related PTSD symptoms were highest among participants who had high Katrina exposure in combination with prolonged stays in transition camps during emigration. Factors that may have contributed to the resilience of the Vietnamese community are discussed.

The Culturally Sensitive Assessment of Trauma-Related Disorder Among Refugees: A Cambodian Example
A culturally sensitive instrument to assess traumatized Cambodian refugees will be described. The assessment instrument has scales that assess (1) *DSM* PTSD symptoms, (2) somatic complaints, including culturally specific somatic complaints, (3) sleep complaints not assessed in the *DSM* criteria (e.g., sleep paralysis), (4) agoraphobia-type cultural syndromes (e.g., "car sickness" and "people sickness"), (5) somatic-symptom-focused cultural syndromes (e.g., "weak heart," "wind attacks," and "hot inside"), and (6) emotion-focused cultural syndromes (e.g., "thinking too much" and "parched mind"). Through an analysis of a large sample (over 200 patients), the relationship between the *DSM*-based PTSD scale and the other scales (and their items) will be discussed.

Can Culture and Values Co-Construct PTSD? A Study in China and Germany
We define "culture" not only by nationality as in cross-cultural research but also by basic value orientations. We conducted a cross-cultural comparison with Chinese and German crime victims and included an assessment of value orientation according to Schwartz´s (1994) theory of cultural values. Traditional (conformity, benevolence, customs orientation) and modern values (achievement, hedonism, stimulation), traumatic exposure, PTSD symptoms, and two psychosocial mediator processes (disclosure intentions, social acknowledgment as a victim) were assessed. 130 Chinese and 151 German adult crime victims were investigated. By means of structural equation multi-sample analysis, data of the two groups were compared. Results: The two patterns of prediction for PTSD differed between the countries on important aspects, i.e., in the German sample both value types were predictive whereas in the Chinese sample only traditional values were predictive of PTSD. Traditional values inhibited social acknowledgment as a victim in China and Germany, whereas in the latter sample, these values were related to increased PTSD severity. Modern values predicted social acknowledgment as a victim as well as recovery in Germany, but not in China. Thus, the study of PTSD may serve as a sample case for the cultural co-construction of mental disorders.

The Debate on PTSD as a Universal Valid Diagnosis Versus a Culture-Bound 'Western' Construct
Respondents in a variety of countries appear to easily recognize PTSD symptoms without any notion of words such as trauma, stress or PTSD. Despite these and neurobiological arguments in favour of a universal PTSD experience, Kendell and Jablensky (2003) have convincingly argued that validity does not mean uniformity across the globe. Although scholars do find PTSD in many different cultures, the conclusion that PTSD is similar in all cultures is premature, since studies generally do not look for differences that might have yielded so-far unknown (sub)types or variations of the disorder. Future interdisciplinary studies should enable the field to parse out the unique and interactive contributions of biology and culture to the PTSD `syndrome´ to increase our understanding how PTSD, posttraumatic idioms of distress, or traumatic personality development are modified by cultural beliefs, meaning systems and cognitive schemata. This lecture argues that such an enterprise would yield a neurobiological and universal core at the biological end of a continuum, with a large variety of culturally induced phenomena at the socio-psychological end of the continuum.

The Clinical Effectiveness of Empirically-Supported Treatments for PTSD

(Abstract #195957)

Symposium/Panel (Clin Res, Practice) **Salon 1, 3rd Floor**

Kehle, Shannon M., PhD[1]; Polusny, Melissa A., PhD[2]; Chard, Kathleen M., PhD[3]; Lewis, Jennifer, PhD[4]; Caldwell, Nicola, PhD[4]; Galovski, Tara E., PhD[5]; Blain, Leah, BA[6]; *Schnurr, Paula P., PhD*[7]; Hembree, Elizabeth A., PhD[8]; Cohen, Sara, BA[8]; Foa, Edna, PhD[9]; Wilt, Timothy, MD, MPH[1], Murdoch, Maureen, MD[1], Hodges, James, PhD[1], MacDonald, Roderick, MS[1]

[1]Center for Chronic Disease Outcomes Research, Minneapolis VA Medical Center, University of Minnesota, Minneapolis, Minnesota, USA
[2]Psychiatry (116B), Minneapolis VA Medical Center and University of Minnesota Medical School, Minneapolis, Minnesota, USA
[3]PTSD and Anxiety Disorders Division, Cincinnati VA Medical Center, Cincinnati, Ohio, USA
[4]Cincinnati VA Medical Center, Cincinnati, Ohio, USA
[5]Psychology, University of Missouri - St. Louis, St. Louis, Missouri, USA
[6]University of Missouri-St. Louis, St. Louis, Missouri, USA
[7]National Center for PTSD (116D), White River Junction VA Medical Center, White River Junction, Vermont, USA
[8]Center for the Treatment and Study of Anxiety, University of Pennsylvania, Philadelphia, Pennsylvania, USA
[9]Department of Psychiatry, University of Pennsylvania, Philadelphia, Pennsylvania, USA

Several treatments for PTSD have been systematically researched and found to be efficacious. However, there has been relatively little research conducted regarding the clinical effectiveness, or generalizability, of empirically-supported treatments (ESTs). The objective of this symposium is to disseminate data regarding the performance of ESTs for PTSD in clinically-representative settings.

The Effectiveness of Cognitive Processing Therapy in Multiple Settings

Cognitive processing therapy (CPT) has been shown to be effective in treating PTSD due to interpersonal violence in several treatment outcome studies. In addition, one randomized, controlled study has provided support for using CPT with veterans.

This Presentation will attempt to further the research by providing data on the use of CPT as part of an efficacy based outpatient PTSD program housed in a VA Medical center. All clinicians (Psychiatrists, Psychologists, Social Workers, and Nurse Practitioners) were trained in using CPT for PTSD related to both combat and interpersonal traumas. Veterans were seen for an average of 14 sessions of individual therapy. All veterans were assessed at pre-treatment and post-treatment with the CAPS, SCID I and II, in addition to the BDI, Trauma Related Guilt Inventory, Coping Strategies Inventory, STAI, STAXI and various positive mental health measures. Data on 40 males and females will be presented, with the expectation that more data will be collected over time. Initial findings suggest that CPT can be an effective treatment when used in an outpatient PTSD program for reducing primary and secondary symptoms. Problems and pitfalls to implementing an efficacy based clinic model will be discussed.

Establishing the Effectiveness of Cognitive Processing Therapy (CPT)

Previous research has established CPT as an empirically-supported treatment. The methodology of previous CPT trials appropriately protected against threats to internal validity in an effort to establish efficacy through the use of highly trained therapists, a fixed number of sessions, and the lack of manual flexibility. Now that internal validity has been established for CPT, this current NIMH-funded study strives to establish effectiveness by more closely mimicking the population and therapists found in community practice. Manual flexibility has been enhanced and length of therapy varied depending on clinical indications. Outcome and therapy termination is based on functional improvement and good end state, as well as diagnostic status. This study seeks to compare a symptom monitoring, delayed control to the modified CPT. Upon conclusion of the control condition, subjects are crossed over to CPT. Outcome and process is primarily measured by symptom monitoring diaries, weekly BDI-II and PDS, and the CAPS. Twenty subjects are currently enrolled in the trial with 5 completions thus far. Twenty more will enter the trial before November with an anticipated 15 more completions. Analyses will assess the status of participant improvement as well as direct comparison to previous research in an effort to test CPT´s effectiveness.

A Systematic Review of the Effectiveness of Exposure-Based Treatments for PTSD

A recent Institute of Medicine review of treatments for PTSD suggested that exposure-based psychotherapies (EBTs) were the only treatments with sufficient empirical support. However, given the limited data regarding the generalizability of EBTs across patient groups, settings, and providers, the report recommended that future research focus on the generalizability, or clinical effectiveness, of EBTs. The goal of the current project is to examine the generalizability of EBTs by analyzing the effect of patient, setting, and provider characteristics on outcomes. This will be accomplished through a quantitative systematic review utilizing published randomized control trials that examined the efficacy of EBTs. In order to examine the clinical effectiveness of the psychotherapies, eligible studies will be coded along dimensions of clinical effectiveness, with particular attention paid to patient (e.g. race, gender, veteran status, trauma type, disability status), setting (e.g. university hospital, community clinic, VA hospital), and provider (e.g. level of training and supervision) characteristics. Meta-analytic techniques will be used to examine the impact of the clinical effectiveness variables on clinician-rated PTSD, self-reported PTSD, and comorbid symptomology. We will discuss gaps in the evidence and make recommendations for future research to close those gaps.

Impact of Random Assignment to Treatment Condition on Expectancy of Outcome and Treatment Retention

We will describe a study of the dissemination of prolonged exposure (PE) at two community-based clinics. Clients were women survivors of sexual assault or childhood sexual abuse with chronic PTSD. Clients at each clinic were randomized to either PE or "treatment as usual" (either group therapy or individual supportive counseling). Treatment preference was assessed at the pre-treatment evaluation after the client heard about and read a brief description of each treatment. Clients understood that their preference would not influence the treatment condition subsequently assigned. Clients completed a treatment outcome expectancy measure in the first session, after learning of their treatment assignment and hearing a rationale for this treatment. The data on treatment preference, treatment expectancy, and dropout from treatment will be used to address several questions: Do clients who do not receive their preferred treatment drop out at a higher rate? Is there differential dropout rate in PE versus treatment as usual, and is this relationship affected by clients´ preferred treatment? Does a match between clients´ preferences and the assigned treatment affect clients´ expectancy of outcome? Is there a relationship between matching clients´ treatment preference and expectancy of outcome that affects dropout? The contribution of these factors to client dropout will be discussed.

PTSD and Intimate Partner Relationships: Correlates and Clinical Implications

(Abstract #196025)

Symposium/Panel (Practice, Clin Res) **Salons 7-9, 3rd Floor**

Schumm, Jeremiah, PhD[1]; Taft, Casey, PhD[2]; Meis, Laura, MA[3]; Sautter, Frederic, PhD[4]; *Keane, Terence, PhD[2]*; O'Farrell, Timothy, PhD[1]; Murphy, Marie, PhD[1]; Weatherill, Robin, PhD[2]; Woodward, Halley, BA[2]; Pinto, Lavinia, MA[2]; Watkins, Laura, BS[2]; Miller, Mark, PhD[2]; Dekel, Rachel, PhD[5]; Murphy, Christopher, PhD[6]; Semiatin, Joshua, MA[6]; Norwood, Amber, BA[6]; Glinn, Shirley, PhD[7]

[1]Families and Addictions Program, Dept of Psychiatry, Harvard Medical School and VA Boston Healthcare System, Brockton, Massachusetts, USA
[2]National Center for PTSD, VA Boston Healthcare System, Boston, Massachusetts, USA
[3]VA Boston Healthcare System, Boston, Massachusetts, USA
[4]Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana, USA
[5]Bar Ilan University, Ramat-Gan, Israel
[6]University of Maryland Baltimore County, Baltimore, Maryland, USA
[7]Los Angeles Veterans Affairs Medical Center and UCLA, Los Angeles, California, USA

This symposium will explore the association between PTSD and various aspects of relationship functioning. Data will be presented from samples of: male combat veterans from a VA PTSD clinic, women seeking substance abuse treatment, men in a civilian domestic abuser program, and OEF-OIF veterans with PTSD.

Intimate Partner and General Aggression Perpetration Among Veterans in a PTSD Clinic

Increasing attention has focused on aggression perpetrated by combat veterans, although the literature is characterized by a lack of standardized measures, a focus on physical aggression only, and a lack of investigations into both intimate partner and general aggression. We examined rates of intimate partner and general physical and psychological aggression perpetration among a sample of 236 male combat veterans seeking PTSD evaluations in a VA clinic, and correlates of these outcomes. Analyses were conducted separately for veterans with and without partners. Approximately 33% of partnered veterans reported intimate partner physical aggression in the previous year, and 91% reported partner psychological aggression. Rates for general physical and psychological aggression perpetration for partnered veterans were 32% and 81%, respectively. For non-partnered veterans, physical and psychological general aggression rates were 39% and 87%, respectively. PTSD and depressive symptoms were associated with various forms of aggression. Associations between combat exposure and aggression were weak. PTSD symptoms reflecting arousal and lack of control was the strongest bivariate and unique predictor of aggression, with some exceptions. The high obtained aggression rates indicate a need for more careful aggression screening and intervention development for the population of interest.

PTSD Symptoms, Substance Abuse, and Partner Violence Among Female Substance Abusers

Studies show a clear link between substance abuse and intimate partner violence (IPV), and women in substance abuse treatment show high rates of IPV and PTSD. While it is apparent that IPV victimization can lead to PTSD, recent data from male veterans suggests that PTSD may also increase IPV perpetration. This study examines the relationships among PTSD, substance abuse, and IPV victimization and perpetration among women seeking substance abuse treatment. Women who were married or cohabitating with a male partner (N = 279) were recruited from a large civilian substance abuse treatment hospital. Participants were assessed at the beginning of their treatment and then followed every 6 months for 18 months. Prevalence of IPV victimization and perpetration exceeded 50%. Structural equation modeling (SEM) provided mixed support for IPV in predicting PTSD. SEM supported independent roles of female PTSD symptoms and female and male partner substance abuse in predicting IPV perpetration and victimization. PTSD hyperarousal symptoms were shown to be especially important in predicting IPV. Results suggest a need for more research on PTSD and IPV among women substance abusers. These findings suggest a strong need for interventions that integrate PTSD and substance abuse treatment while targeting reductions in IPV.

Traumatic Experiences and Symptoms of PTSD in a Clinical Sample of Intimate Partner Violent Men

Studies have documented high rates of witnessed and experienced childhood abuse among partner violent men. However, little research has examined exposure to other trauma or PTSD symptoms in this population. The current study examined trauma exposure and PTSD symptoms among 128 men seeking treatment for partner abuse perpetration, 81 of whom had collateral partner data. Eighty percent of participants endorsed at least one traumatic event, and the average PCL-C in the sample was 29 (SD = 17). Nine percent of cases (n = 11) met the cutoff of 50 used to indicate a probable PTSD diagnosis. Trauma exposure was associated with psychological abuse perpetration and general violence after controlling for child abuse and witnessing of interparental violence. PTSD symptoms were associated with relationship problems, psychological abuse, binge drinking, and partner violence perpetration after controlling for substance use problems and childhood exposure to family violence. After controlling for relationship problems, associations between PTSD symptoms and physical abuse were no longer significant. Results suggest that traumatic exposure and PTSD symptoms may have unique associations with IPV perpetrators´ interpersonal and relational problems, beyond the effects of family of origin abuse and violence. They also highlight the role of substance use and relationship problems.

The Development of a Couple-Based Intervention to Improve the Management of Anxiety and Emotion in OEF/OIF Veterans With PTSD and Their Spouses

This presentation reports findings regarding the development of a novel couple-based treatment, named Strategic Approach Therapy (SAT), to improve the management of emotions and anxiety in veterans with PTSD and their spouses. SAT employs dyadic stress inoculation procedures, communication training, and problem-solving to teach couples to develop relational skills that allow them to manage the anxiety and difficult emotions that often devastate the relationships of people with PTSD. This manualized intervention consist of 10 sessions and is provided to groups of 2-3 couples by two therapists. Data will be presented from a small sample of six Vietnam veterans and their spouses showing statistically significant reductions in self-reported, clinician-rated, and partner-rated effortful avoidance, emotional numbing, and overall PTSD severity. Findings from an ongoing study using the SAT program intervention with OEF/OIF veterans and their spouses will also be presented. Data suggest that SAT offers promise as an effective treatment for PTSD in OEF/OIF veterans and that it may be used to encourage OEF/OIF veterans to become engaged in other PTSD treatments.

Spreading Best Practices to Communities: Results From Two Statewide Implementations of TF-CBT

(Abstract #196078)

Symposium/Panel (Clin Res, Commun) **Salon 3, 3rd Floor**

Lang, Jason, PhD[1]; Fitzgerald, Monica, PhD[2]; Franks, Robert, PhD[3]; Hanson, Rochelle, PhD[2]; Saunders, Benjamin, PhD[2]; Ralston, Elizabeth, PhD[4]; Sawyer, Genelle, PhD[5]; *Markiewicz, Jan, MED[6]*

[1]Connecticut Center for Effective Practice, University of Connecticut, Farmington, Connecticut, USA
[2]Medical University of South Carolina, Charleston, South Carolina, USA
[3]Yale University, New Haven, Connecticut, USA
[4]LCC, Charleston, South Carolina, USA
[5]Medical University of South Carolina, Lincoln, Nebraska, USA
[6]Duke University Medical Center, National Center for Child Traumatic Stress, Durham, North Carolina, USA

Past efforts to disseminate evidence-based practices to community settings have shown limited success. The Learning Collaborative is a quality improvement model designed to spread best practices through system-wide organizational change. We will describe and present initial results from two statewide efforts to disseminate TF-CBT using the Learning Collaborative methodology.

The Connecticut TF-CBT Learning Collaborative
Initial findings from a statewide effort to disseminate Trauma Focused Cognitive-Behavioral Therapy (TF-CBT) to outpatient clinics across Connecticut using the Learning Collaborative methodology will be presented. The Connecticut Center for Effective Practice (CCEP), a unique partnership between state agencies, academic institutions and an independent policy and research institute, is serving as the TF-CBT Coordinating Center. This initiative will be placed in context with a brief history of the state´s efforts to implement other EBPs and to develop a trauma informed system of care. Connecticut´s adaptations to the Learning Collaborative model will be described, including funding mechanisms, extensive training on assessment and using measures, online data management, training of referrers, and the inclusion of caregiver advocates at all sites. Agency staff at up to 18 clinics over three years are participating. We will present aggregate Learning Collaborative outcome data using measures at the agency (organizational readiness), therapist (caseload, supervision, fidelity, EBP attitudes) and client (symptom) levels. Agency and clinician predictors of improved outcomes will be presented. The implications and challenges of disseminating EBPs on a statewide level will be discussed.

Project BEST
Project BEST (Bringing Evidence Supported Treatments to South Carolina) is in the first 3-year phase of a 10-year collaborative project to deploy evidence-supported treatments (EST) throughout South Carolina to improve access to high quality mental health services for traumatized youth and their caregivers. The aim of Phase 1 is to test the Community-Based Learning Collaborative (CBLC) approach to training, implementation, and sustained use of TF-CBT in four areas of South Carolina. This initiative involves 42 clinicians from 27 different agencies, as well as 24 "brokers" of mental health services (i.e., those who identify and refer abused children to treatment providers). The CBLC approach includes multiple advanced trainings, action period tasks, ongoing case consultation, and other types of technical assistance. We will present initial findings from Project BEST testing whether specific individual and organizational factors are associated with successful adoption of TF-CBT. These indicators of community 'readiness' include individual therapist factors, such as openness to change and willingness to adopt an EST; baseline competency in TF-CBT; as well as organizational factors such as openness; awareness; and availability of resources. Successful adoption of TF-CBT is measured by clinician-reported use of TF-CBT, broker-reported referrals and engagement in TF-CBT.

Imagery Rehearsal for Nightmares: RCT With Vietnam War Veterans, Pilot With OIF Returnees and Beyond

(Abstract #196108)

Symposium/Panel (Clin Res, Practice) **Adams Ballroom, 6th Floor**

Cook, Joan, PhD[1]; Harb, Gerlinde, PhD[2]; *Ross, Richard, MD, PhD[2]*; Gamble, Geraldine, RN[3]; Gehrman, Philip, PhD[4]

[1]Department of Psychiatry, Yale University School of Medicine, West Haven, Connecticut, USA
[2]Philadelphia VA Medical Center, University of Pennsylvania, Philadelphia, Pennsylvania, USA
[3]Behavioral Health Department, Philadelphia VA Medical Center, Philadelphia, Pennsylvania, USA
[4]University of the Sciences in Philadelphia, Philadelphia, Pennsylvania, USA

Increasing evidence supports a promising cognitive-behavioral therapy, Imagery Rehearsal (IR), for the treatment of posttraumatic nightmares. This symposium will discuss three investigations of IR: a randomized controlled trial (RCT) in Vietnam War veterans, an open trial in Operation Iraqi Freedom (OIF) returnees and the design of a recently funded RCT in OIF and Operation Enduring Freedom veterans.

Imagery Rehearsal: Evidence, Description, and Examples
There is increasing evidence that posttraumatic nightmares respond to an empirically promising cognitive-behavioral therapy called Imagery Rehearsal (IR). In IR, patients choose a repetitive nightmare related to a traumatic event, change it during waking so that it is less distressing, and then mentally rehearse the changed dream script. In addition, IR encompasses psychoeducation regarding Posttraumatic Stress Disorder and nightmares as well as progressive muscle relaxation. This presentation will: (1) briefly review the data supporting the use of IR, including previous studies and RCTs in different populations; (2) describe treatment techniques used in IR, including suggestions for and examples of changing nightmares (such as alternate endings, insertion of reminders into a dream that prompt different ways of viewing it, and distancing techniques); and (3) briefly discuss the content of nightmares and the rescripting of nightmares in our Vietnam War veterans sample.

Imagery Rehearsal for Posttraumatic Nightmares in Vietnam War Veterans: A Randomized Controlled Trial
This presentation will describe the primary findings from a randomized controlled trial of Imagery Rehearsal versus Sleep and Nightmare Management, a psychotherapy comparison condition, in Vietnam War veterans with combat-related PTSD and nightmares. One hundred and twenty-four veterans were randomized to treatment. Intention-to-treat and completer analyses will be presented for the primary outcomes, nightmare frequency and sleep quality, as well as for secondary outcomes, psychosocial impairment attributed to nightmares, PTSD and depressive symptoms. There were no baseline differences between treatment groups on any outcome measure. There were significant differences between treatment groups in regards to dropout, which will be presented and discussed. Mixed effects models will be used to analyze the effects of treatment across time while accounting for baseline covariates and clustering within therapy groups. Interpretation of these results in the context of current evidence as well as generalizability to other traumatized groups will be discussed.

Open Pilot Study of Imagery Rehearsal with OIF Returnees and Design of Bi-Site RCT in OEF/OIF Veterans
The purpose of this presentation is: (1) to report on pilot data obtained in an open trial of IR in OIF veterans, and (2) to present the design of a recently funded Department of Defense bi-site RCT in OEF/OIF veterans. A pilot study of a treatment that combined IR with elements of standard cognitive-behavioral treatment (CBT) for insomnia was conducted in a small sample of OIF veterans. Results

are promising, both with regard to feasibility and efficacy. Pre-post analyses indicated improvement in both nightmare frequency (4; t=.95, d=0.47) and global sleep quality (5; t=1.61, d=0.56), with a small decrease in overall PTSD symptomatology (6; t=1.62, d=0.29). The combination treatment appears to allow OIF returnees to engage in problem-solving of practical changes in sleep habits while beginning the more challenging work of ameliorating posttraumatic nightmares. The design of a recently funded RCT of IR for OEF/OIF returnees will also be presented. This investigation is a bi-site RCT (Philadelphia VA Medical Center/University of Pennsylvania and National Center for PTSD/Yale University). In addition, the study will also investigate neuropsychological variables important in this population of veterans as well as a possible biological marker of the PTSD-related sleep disturbance.

Mental Health Lessons Learned From the American Red Cross Response to the World Trade Center Attack

(Abstract #196063)

Symposium/Panel (Disaster, Prev EI) **Wabash Room, 3rd Floor**

Tramontin, Mary, PsyD[1]; Halpern, James, PhD[2]; Ryan, Diane, LCSW[3]; Avila, Luis, BA[4]; White-Tapp, Maggie, LCSW[5]
[1]American Red Cross in Greater New York, Disaster Mental Health Leadership Committee, New York, New York, USA
[2]State University of New York at New Paltz, New Paltz, New York, USA
[3]American Red Cross in Greater New York, Director, Mental Health Disaster Planning and Response, New York, New York, USA
[4]Sr. Director, Emergency Services, American Red Cross of Greater Miami and The Keys, Miami, Florida, USA
[5]Maggie W. Tapp Consulting, Charlotte, North Carolina, USA

Mental health lessons learned concerning aspects of the three broad stages of a terrorist attack---preimpact (preparedness, planning, warning, threat), impact (inventory, rescue) and postimpact (reconstruction, recovery)---are discussed by key American Red Cross personnel involved on 9/11. The management and mitigation of terrorism engendered traumatic stress are highlighted.

Introduction to Humanitarian Relief Work
For more than 120 years, volunteers and employees of the American Red Cross have assisted those overwhelmed by the needs created by disasters. Assistance has been as simple as a warm plate of food, or as complex as a team of licensed mental health professionals responding to family members after an airline disaster. Nationally, The American Red Cross responds to more than 70,000 disasters yearly, from single-family fires to wildfires to hurricanes to terrorist attacks. We are the premier organization providing humanitarian relief during critical times. A defining moment for this country, and this organization, were the attacks on September 11th. Our New York City based response to the World Trade Center Attacks stressed every element of our team; the enduring commitment and professionalism of our volunteers and staff to assist those in need kept us moving forward with our mission. This presentation will provide information on the evolution of mental health services into the work of the American Red Cross in Greater New York and illustrate how mental health workers and Red Cross responders worked together during the response to the WTC attacks.

Initial Impact
Issues of physical safety for all disaster mental health workers and how to best deploy them are crucial during the impact phase of a disaster. This is discussed from the perspective of the American Red Cross response to the World Trade Center attack. In the aftermath of 9/11, members of the mental health community in New York City were also traumatized, thus blurring the boundary between helpers and victims. Counselors who are directly or indirectly impacted by terrorist attacks may be deeply affected themselves or even impaired to function in their roles. Such impairment needs to be planned for, assessed and mitigated. Another key aspect of the impact phase that will be featured is that beginning on the evening of 9/11 the major point of contact between survivors and counselors was over the phone via the Missing Persons Hotline. Family member and friends of those missing, neighborhood residents who could not return to their homes or find pets made tens of thousands of calls. Lessons learned concerning effective phone crisis counseling during the impact stage are discussed.

Disaster Mental Health Interventions September 2001 Through June 2002
Commencing on September 11th, 2001, the Greater New York Chapter of the American Red Cross deployed disaster mental health workers who provided an array of services until the WTC site was officially closed in June of 2002. The range of intervention sites will be outlined along with the underlying rationale for such services and the types of psychological support offered. Locations discussed include family assistance centers, respite areas for recovery workers, impacted resident outreach, Ground Zero, memorials, morgue support and the "last load" ceremony. Unique aspects of the application of mental health interventions during a disaster recovery project of very large scope, intensity, and duration will be highlighted. Specifically, the role of close, organized partnerships with non mental health service providers such as chaplains will be explicated. Finally, methods of practitioner self care employed during this time period, including the use of debriefings, will be reviewed.

Putting 9/11 into Perspective-What is Different Now?
This piece of our presentation will outline the organizational lessons learned following the attack on the World Trade Center, how that response has shaped planning for future events and changes in the role of disaster mental health workers at the American Red Cross in Greater New York since 9/11/01. Concepts such as the importance of pre-incident interdisciplinary relationships in planning and preparedness activities, strategies for building a large and well trained core of mental health workers for future need, developing a management plan for spontaneous volunteers and systems for screening and supporting workers during a prolonged mass casualty event will be discussed. Historically, Red Cross chapters that are affected by a mass casualty event experience the loss of significant numbers of staff members and volunteers who leave the field of disaster intervention. Thoughts on why humanitarian responders at the American Red Cross in Greater New York continue to be active in the field despite being affected by the World Trade Center attack will be shared.

A Case Study Using the Trauma Assessment Pathway (TAP) Model

(Abstract #196340)

Workshop/Case Presentation (Practice, Child) **Salon 2, 3rd Floor**

Killen-Harvey, Al, LCSW[1]; Conradi, Lisa, PsyD[2]
[1]Chadwick Center for Children and Families, Rady Children's Hospital, San Diego, California, USA
[2]Chadwick Center for Children and Families, San Diego, California, USA

This highly experiential workshop will discuss, "Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway Model (TAP)." TAP is an assessment-based treatment model developed by the Chadwick Center at Rady Children´s Hospital, San Diego, and has demonstrated effectiveness in clinic-based settings for treating children and adolescents between two and 18 years of age who experienced any type of trauma. TAP incorporates assessment, triage, and evidence-supported components of trauma treatment into clinical pathways and includes a Treatment model that focuses on addressing the needs of complexly traumatized children via a Trauma Wheel. Following a brief discussion that will provide necessary background

information for designing and making decisions within an assessment-based treatment protocol, the presenters will prepare a case study of a complexly traumatized child who received therapy using the Treatment component of TAP Model. The components of the Trauma Wheel will be discussed as they apply to this case and audience participation will be highly encouraged. An algorithm discussing how to use the essential components of trauma treatment in this and other cases will be presented along with a discussion of how the TAP model can be adapted for various cultural populations.

Assessing and Enhancing Treatment Engagement in OEF/OIF Veterans

(Abstract #196445)

Workshop/Case Presentation (Mil Emer, Practice) **Salons 4-6, 3rd Floor**

Murphy, Ronald, PhD[1]; **Stanton, Theresa, BA**[1]
[1]*Psychology, Francis Marion University, Florence, South Carolina, USA*

Research shows that many Iraq and Afghanistan veterans who need help for post-deployment problems such as PTSD are not seeking help. Unfortunately, treatment engagement issues in PTSD have rarely been addressed either by researchers or clinicians in the field. The first goal of the workshop is to teach participants how to assess barriers to treatment engagement among veterans, including problem acknowledgement, therapeutic alliance, expectancies and fears about PTSD treatment, stigma and other cognitive/attitudinal barriers, and perceptions of treatment credibility and relevance. The second goal of the workshop is to provide practical and clear strategies for increasing problem acknowledgement, fostering strong therapeutic alliance, and modifying irrational or inaccurate beliefs related to treatment. Specific techniques include methods of strengthening and repairing ruptures in therapeutic alliance in PTSD treatment, activities from the PTSD Motivation Enhancement Group that increase problem acknowledgement and reduce externalizing/blaming attributions, ways of avoiding common therapeutic pitfalls with newly-returned veterans early in treatment, and ambivalence reduction strategies. Participants will be encouraged to engage in behavioral rehearsal and to discuss treatment engagement issues arising in their own work.

Concurrent Session 5
Friday, November 14
8:00 a.m. – 9:15 a.m.

DSM-V
Introduction to the Anxiety Disorders *DSM-V* Process

An Update on the *DSM-V* Development Process

(Abstract #196612)

DSM-V (Asses Dx, Practice) **Grand Ballroom, 4th Floor**

Phillips, Katharine A., MD[1]; **Friedman, Matthew, MD, PhD**[2]
[1]*Professor of Psychiatry and Human Behavior, The Warren Alpert Medical School of Brown University, Providence, Rhode Island, USA*
[2]*National Center for PTSD, White River Junction, Vermont, USA*

The development of *DSM-V* is under way. This presentation will discuss important groundwork that has been laid for the development of *DSM-V*, including white papers that have been published ("A Research Agenda for *DSM-V*") and *DSM-V* research planning conferences that have been held in recent years. The current status of the *DSM-V* development process will be described. In addition, some of the key considerations that are guiding the development of *DSM-V* – such as attention to gender and cross-cultural issues, developmental considerations, and the psychiatric/general medical interface – will be discussed. Where does PTSD fit in the overall classification system?

Where Does PTSD Fit in the Overall Classification System?

Should PTSD Continue to be Classified as an Anxiety Disorder?

(Abstract #198262)

DSM-V (Asses Dx, Res Meth) **Grand Ballroom, 4th Floor**

Resick, Patricia, PhD[1]
[1]*National Center for PTSD/Boston VA Healthcare System, Boston, Massachusetts, USA*

Posttraumatic stress disorder has been classified as an anxiety disorder since it´s inception in 1980. On one hand, this classification is logical because of the level of fear that often accompanies traumatic events, the conditioning that appears to occur with previously neutral cues, and the influence of avoidance on the maintenance of the disorder. On the other hand, there is also evidence that fear may not be the best predictor of who does or does recover from traumatic events such that a diagnosis of PTSD is warranted, and does not capture the array of other emotions such as anger, shame, sadness, or grief that may also accompany the disorder or even predominate in many cases. This talk will describe where PTSD falls with recent efforts to factor analyze Axis I diagnoses and will review studies that attempt to predict who will develop PTSD following trauma, to examine the question of whether PTSD is truly an anxiety disorder or should be classified elsewhere.

Is PTSD a Stress Induced Fear Circuitry Disorder?

(Abstract #197880)

DSM-V (Bio Med, Asses Dx) **Grand Ballroom, 4th Floor**

Shin, Lisa, PhD[1]
[1]*Department of Psychology, Tufts University, Medford, Massachusetts, USA*

To address the question of whether PTSD is a stress induced fear circuitry disorder, this presentation will summarize recent relevant functional neuroimaging findings in PTSD. Many recent studies

have reported hyperresponsivity in the amygdala and dorsal anterior cingulate cortex, and hyporesponsivity in the ventral medial prefrontal cortex in PTSD. Recent research using a monozygotic twin design has suggested that exaggerated glucose metabolism and fMRI activation in the dorsal anterior cingulate is a familial risk factor for the development of PTSD after psychological trauma. In summary, several brain regions in the "fear network" appear to function abnormally in PTSD, and functional abnormalities in one of these regions (dACC) appear to act as a familial risk factor. Future research using twin and longitudinal designs will be needed to determine whether other functional abnormalities act as risk factors versus acquired signs of PTSD.

Participant Alert: Participant distress is extremely unlikely. Some participants who dislike viewing MRI images of the brain may be uncomfortable viewing such images in this presentation.

Should PTSD be Included in a New Cluster of Post-Event Psychiatric Disorders?

(Abstract #198300)

DSM-V (Asses Dx, Practice) **Grand Ballroom, 4th Floor**

Keane, Terence, PhD[1]
[1]*Boston VA Healthcare System, Boston, Massachusetts, USA*

Over the past thirty years, we´ve entertained the inclusion of PTSD in the overarching categories of Anxiety Disorders and Mood Disorders. New data are emerging that suggest that PTSD belongs in neither category; it shares some characteristics in common with each. PTSD also shares characteristics with personality disorders and with dissociative identity disorders. The current presentation focuses on the need for reconsidering the matter entirely. PTSD might well be included in a distinct category of conditions that are roughly viewed as post-event psychiatric disorders. A rationale for this model will be presented as will data supporting the creation of a new overarching category that will encompass several extant psychiatric conditions under this diagnostic category. Evidence will be drawn from psychometric studies, from neurobiological studies, longitudinal cohort research, and behavioral genetics. The importance of viewing trauma symptomatology as dimensional, secondary to recent taxonometric studies will be highlighted.

Integrating Human Rights Principles Into Clinical Practice: Working With Refugees and Asylum Seekers

(Abstract #198266)

Master (Civil Ref, Cul Div) **Crystal Room, 3rd Floor**

Steel, Zachary, MCLINPSYCH, MAPS[1]
[1]*School of Psychiatry, University NSW, Center for Population Mental Health Service, Liverpool, New South Wales, Australia*

In both western countries and in the developing world, refugee and asylum seekers face multiple ongoing threats to their mental health and well being. Many of these challenges are a direct result of state polices of deterrence which breech fundamental human rights principles. The clinician working with these populations must face these difficulties if they are to provide support, care and treatment to their clients. This workshop explores how an understanding of human rights principles can help the clinician in their therapeutic work in these and other settings. The three broad generations of human rights: civil and political rights; economic, social and cultural rights; and group and collective rights will be reviewed. The position of the therapist is rendered more complex as he or she is also a member of the society that is responsible for the human rights violations experienced by their clients. Threats within each of these broad domains can, thus, not only directly affect the client but undermine the therapeutic relationship. The experience of clinicians in Australia over the previous decade has underscored the need to understand clinical practice within a broader socio-political context. Similarly the experience of clinicians working in post-conflict environments underscores the need to develop a broader understanding of clinical care and treatment. By way of case example the workshop will illustrate the dangers facing the clinician who fails to take account of the broader human rights context of treatment. The final section will demonstrate practical steps for integrating core human rights principles and analysis into cognitive behavioural clinical formulations and treatment.

Profiles of Resilience, Coping, and Adaptation: Survivors Tell Their Stories

(Abstract #196310)

Media Presentation **Salons 4-6, 3rd Floor**

Hollander-Goldfein, Bea, PhD[1]; **Perlo, Aviva, MSW**[1]
[1]*Council for Relationships, Transcending Trauma Project, Philadelphia, Pennsylvania, USA*

In this DVD of profiles of resilience, coping, and adaptation, ten survivors of trauma and their families convey first-hand accounts of war, genocide, gun violence, sexual abuse, close encounters with suicide, and what it is like living with limited mobility. The populations featured vary in age, cultural background, and types of trauma endured. The interviewer´s questions focus on coping, adaptation, and resilience, rather than historical details. The narratives address the short-term and long-term impact of trauma, Posttraumatic stress and Posttraumatic growth, as well as the role of psychotherapy in the process.

Common findings emerge among the diverse interviews. Whether a refugee from Yuganda, a Holocaust survivor, a survivor of sexual abuse by clergy or a survivor of gun violence; survivors demonstrate mechanisms of coping and adaptation in the aftermath of extreme trauma. As we witness survivors telling their stories, nuances in tone, intonation, and emotional emphasis offer a increased understanding of what it means to survive trauma and how to treat survivors. The impact of trauma does not dissipate but its negative affect diminishes over time.

Participant Alert: Distress may result from watching this DVD and hearing survivors tell their stories of encountering trauma.

The European Network for Traumatic Stress: Evidence Based Practice for Disaster Victims in Europe

(Abstract #196144)

Symposium/Panel (Disaster, Cul Div) **Salon 3, 3rd Floor**

Witteveen, Anke, PhD[1]; **Nordanger, Dag, PhD**[2]; **Ajdukovic, Dean, PhD**[3]; **Bisson, Jonathan, DM, FRCPSYCH**[4]; **Olff, Miranda, PhD**[1]; **Johansen, Venke A., PhD**[2]; **Tavakoly, Behrooz, PhD**[4]
[1]*Psychiatry, Academic Medical Center Amsterdam, Amsterdam, Netherlands*
[2]*Resource centre for violence, traumatic stress and suicide prevention - Western Norway (RVTS-West), Helse Bergen - Haukeland University Hospital, Bergen, Norway*
[3]*Department of Psychology, University of Zagreb, Zagreb, Croatia*
[4]*Department of Psychological Medicine, Cardiff University, Cardiff, Wales, United Kingdom*

At present post disaster activities and plans seem to vary widely across the European region. The European Network for Traumatic Stress (TENTS) aims to build capacity of evidence based and effective post disaster mental health services in countries across Europe. Findings from two main elements of TENTS will be discussed.

Mapping Existing Services for Post-Disaster Psychosocial Care Across Europe: Quantitative Findings
The European Network for Traumatic Stress (TENTS) aims 1) to map the current situation of posttraumatic stress treatment for victims of disasters in countries and regions across the European region; 2) to compare results from the mapping analysis with an evidence based model developed along with a systematic review

of the literature on posttraumatic stress treatment and psychosocial support for disaster victims; 3) to develop dissemination materials (teaching materials) tailored to the local needs in every country and 4) to start local implementation of the disseminated materials. This presentation will outline the quantitative results of the mapping work package (aim 1). We gathered address information of over 500 services involved in post disaster psychosocial health care from 33 countries and regions in Europe and invited them to participate in our study. The responding services were asked to fill out a web-based questionnaire about planning and coordination of post disaster psychosocial care, availability of human resources, screening instruments and interventions, and training and supervision of staff. Results of the questionnaire will be presented, area-specific needs will be analysed and challenges of disseminating and implementing services in a post-disaster environment will be discussed.

Post Disaster Structures and Resources in Romania and Norway
As part of The European Network for Traumatic Stress (TENTS)´s ongoing process of mapping existing structures and resources on post disaster psychosocial follow-up throughout European countries, the present study investigates the situation in Romania and Norway respectively. Data on targeting structures, resources and working methods of post disaster services are partly collected through the mapping questionnaire developed by TENTS and partly through semi-structured individual and focus group interviews with key professionals in each country, going in depth on the same issues. Preliminary results show that the two settings differ substantially in historical, socioeconomic and socio-cultural terms. In the presentation of the results we will address how contextual differences are reflected in the organization and content of post disaster services, and in the perceptions of survivors´ needs. In particular, certain socio-cultural factors will be discussed in terms of their implications for challenges and considerations´ in the final capacity building phase of the TENTS project, where dissemination material tailored to each setting shall be developed and implemented.

Services and Psychosocial Care After Disasters—Qualitative Findings from South East Europe
Mapping of services for psychosocial care of trauma victims after disasters within The European Network for Traumatic Stress (TENTS) included qualitative data. Interviews and focus groups were done with key informants in Croatia, Bosnia & Herzegovina, Serbia, Slovenia and Macedonia. They included mental health providers and managers from governmental and non-governmental services involved in serving traumatized populations (psychiatric hospitals, community mental health centres, rescue services, disaster planning authorities, voluntary organizations, Red Cross, professional associations). The number of informants from 9 (Croatia, Serbia) to 3 (Slovenia, Macedonia) reflect the current level of delivery of psychosocial care and the stage of planning services after disasters. In Croatia, Slovenia and Serbia, the master planning is in the early stage, while it is still not on the agenda in Bosnia & Herzegovina and Macedonia. More experiences with traumatized survivors, mostly resulting from the recent war, is related to more advanced services and planning of psychosocial care for victims of disasters. Croatia has a network of 136 providers specifically trained in community-based psychosocial crisis interventions capable to respond on a short notice. It was developed within a non-governmental organization over 13 years and will become a part of the national disaster response.

Psychosocial Model of Care Following Disasters: Achieving Consensus Using the Delphi Method
Despite increasing research that has evaluated the efficacy of approaches aimed to prevent or reduce distress following traumatic events there is little evidence on which to base a psychosocial model of care. The European Network for Traumatic Stress decided to use the Delphi method to achieve a consensus on what should be included in an optimal model of care by consulting individuals with an expertise in this area. Service users, clinicians, researchers and planners all took part. 106 (87%) of the individuals approached took part. The Delphi process comprised 3 rounds. During the first round individuals were presented with a set of statements and asked to rate how important they felt they were using a visual analogue scale. They were also asked to comment on their responses. During the second round the results were fed back to participants and they were asked to reconsider their views in the light of the results and comments of other participants. Round three was used to address issues that had not already been resolved using the same methodology. The results were used to help prepare a model of care which will be presented along with detailed results of the Delphi survey.

Addressing Barriers to Service Utilization for Returning Iraq and Afghanistan Veterans and Families

(Abstract #196178)

Symposium/Panel (Mil Emer, Clin Res) **Adams Ballroom, 6th Floor**

Scotti, Joseph R., PhD[1]; Polusny, Melissa, PhD[2]; Unger, William, PhD[3]; Whealin, Julia, PhD[4]; *Lyons, Judith A., PhD*[5]; Majewski, Virginia, PhD, MSW[6]; Tunick, Roy, EDD[7]; Heady, Hilda, MSW[8]; Erbes, Christopher, PhD[2]; Arbisi, Paul, PhD[2]; Thuras, Paul, PhD[2]; Reddy, Madhavi, MA[2]; Kehle, Shannon, PhD[9]; Erickson, Darin, PhD[10]; Murdoch, Maureen, MD, MPH[11]; Rath, Michael, MD[12]; Courage, Cora, PsyD[13]; Woolaway-Bickel, Kelly, PhD[14]; Southwick, Steven, MD[15]

[1]Department of Psychology, West Virginia University, Morgantown, West Virginia, USA
[2]Psychiatry (116B), Minneapolis VA Medical Center and University of Minnesota Medical School, Minneapolis, Minnesota, USA
[3]Psychology, PTSD Clinical Team, Providence VA Medical Center, Providence, Rhode Island, USA
[4]VA Pacific Islands Health Care Network, National Center for PTSD, Pacific Islands Division, Honolulu, Hawaii, USA
[5]Trauma Recovery Program, G.V. "Sonny" Montgomery VAMC, South Central MIRECC & University of Mississippi Medical Center, Jackson, Mississippi, USA
[6]Department of Social Work, West Virginia University, Morgantown, West Virginia, USA
[7]Department of Counseling, Rehabilitation Counseling, & Counseling Psychology, West Virginia University, Morgantown, West Virginia, USA
[8]Office of Rural Health, West Virginia University, Morgantown, West Virginia, USA
[9]Psychiatry (116B), Minneapolis VA Medical Center, Minneapolis, Minnesota, USA
[10]School of Public Health, University of Minnesota, St. Paul, Minnesota, USA
[11]Center for Chronic Disease Outcome Research, Minneapolis VA Medical Center, Minneapolis, Minnesota, USA
[12]Minnesota Army National Guard, Mankato, Minnesota, USA
[13]Minnesota Army National Guard, Evanston, Wyoming, USA
[14]National Center for PTSD, Pacific Islands Division, Honolulu, Hawaii, USA
[15]Psychiatry, Yale University, West Haven, Connecticut, USA

We report on the impact of the wars in Iraq and Afghanistan on returning veterans. Findings related to under-utilization of services will be presented, including problems of access, cultural and personal beliefs, and lack of satisfaction. Means for overcoming barriers and providing access and support to veterans and families will be discussed.

WV Veterans Returning From Iraq and Afghanistan: Impact on Personal and Family Functioning
A state-wide mail survey of 1,000 West Virginia Veterans who had one or more deployments in Iraq or Afghanistan was conducted over the period of November 2007 to March 2008. The respondents (10% female; mean age = 34) completed basic demographics (income, employment, education, etc.) and measures of combat exposure, PTSD, depression, and personal and family functioning. We will present the relations between several indices of combat exposure and reported symptoms of PTSD and/or depression. Overall, 45% of the sample met criteria for PTSD and/or

depression. Veterans with PTSD and or depression (P/D) were more likely than Other Veterans (OV) to report statistically significant declines in personal and family functioning; including general physical health, family relationships, social support, and the behavior and academic progress of their children. Mediators and moderators of the impact of exposure and psychological symptoms on family functioning will be presented. Further, those veterans who served with National Guard units (versus regular Army) reported higher levels of symptoms. The implications of these findings for identifying veterans in need and providing services to them and their families will be discussed. [Scotti and colleagues]

Mental Health Risk and Resilience in OIF Deployment National Guard Soldiers: Prospective Predictors
Combat exposure and deployment stressors are associated with the risk of PTSD, depression, and alcohol abuse. Understanding factors that increase risk and promote resilience is critical; existing literature is limited by retrospective, cross-sectional designs, and a focus on active duty personnel. Little is known about individual factors influencing outcomes among National Guard soldiers deployed to OEF/OIF. The Readiness and Resilience in National Guard Soldiers (RINGS) Cohort Study is a prospective, 4-wave investigation of the effects of pre-deployment, deployment, and post-deployment risk and resiliency factors on mental health outcomes, service utilization, and military retention/attrition. In March 2006 (a month prior to OIF deployment), a representative sample of 522 male and female National Guard soldiers completed a battery of instruments that assessed pre-deployment risk factors and baseline mental health. Using mail surveys, we plan to collect three waves of follow-up data from this cohort. We will present findings from the initial post-deployment assessment (74% current response rate, with non-response appearing minimal). Prospective pre-deployment predictors of initial post-deployment psychological and social functioning will be examined. Implications of the findings for intervening with returning military personnel will be discussed. [Polusny and colleagues]

Developing Outreach, Education, Prevention and Mental Health Services for Returning OEF/OIF Veterans
The PTSD Clinical Team (PCT) at Providence VAMC has provided mental health services to veterans for 18 years and has actively treated stress-related problems of veterans returning from Iraq and Afghanistan. Early assessment and treatment of PTSD and co-morbid disorders related to war exposure is critical. A priority for the PCT has been outreach to both service members and families, with about 6,000 contacts over the past five years. By providing education and establishing contacts with returnees and their families, we can reduce barriers and improve access to care by increased awareness of signs/symptoms of PTSD and other problems. The clinical needs of newly returned veterans are assessed individually. Family evaluations are done, as needed. to date, the PCT has provided treatment to about 850 veterans of Iraq and Afghanistan. We have identified and addressed barriers to veterans seeking mental health services. The treatment focus is rehabilitation, health promotion, and preventative care; the goal is recovery of function to the greatest degree possible. The program was developed in response to the barriers to service utilization identified, and employs the Clinical Practice Guidelines for Management of Posttraumatic Stress Disorder (VA/DoD National CPG Council, 2003). Data on outreach effectiveness and entry into follow-up treatment will be discussed. [Unger and colleagues]

Cultural and Logistical Barriers to Mental Health Care of OIF/OEF Veterans in the Pacific Islands
Whereas the majority (78-86%) of war returnees acknowledge a need for help with mental health issues, less than one third (13-27%) follow through with mental health services (Hoge et al, 2004). We designed the present study to clarify the nature of barriers to mental health care among an ethno-culturally diverse group of OIF/OEF veterans referred for VA treatment for trauma-related problems. Forty subjects completed the Perceived Barriers to Care (Hoge et al., 2004), the Cultural Barriers to Care (Whealin, 2007), and the Beliefs about Psychotropic Medications and Psychotherapy (Bystritsky et al., 2005) inventories. Results showed that the majority reported beliefs and/or logistical obstacles that impeded their willingness and ability to receive care in traditional mental health clinics. Additionally, cultural beliefs correlated with attitudes about psychotropic medications and psychotherapy. Based upon these results, we will present tactics to enhance treatment outreach programs, and discuss methods for incorporating the preferences and beliefs of veterans into treatment. [Whealin and colleagues]

The North Sea Oil Rig Disaster of 1980 Revisited and a Preventive Rock Slide Study

(Abstract #196223)

Symposium/Panel (Disaster, Res Meth) **Salons 7-9, 3rd Floor**

Hoyer Holgersen, Katrine, PsyD[1]; Boe, Hans Jakob, PsyD[1]; Holen, Are, MD, PhD[2]; Rod, Kjetil, MA[3]
[1]Dept. of Neuroscience, Norwegian University of Science and Technology, Trondheim, Norway
[2]Dept. of Neuroscience (INM), Norwegian University for Science and Technology, Trondheim, Norway
[3]Dept. of Neuroscience, Norwegian University of Science and Technology, Molde, Norway

The first three presentations cover preliminary findings from a 27-years follow-up study of survivors from the North Sea Oil Rig Disaster (1980). Whenever possible, the long-term and current data from survivors will be compared with matched oil rig workers unexposed to disaster; they also have been studied over decades. The fourth presentation will focus on preventive communication and risk perception in relation to a major potential rock slide.

Predicting Posttraumatic Growth in an Aging Disaster Population
Predictors of current reports of Posttraumatic growth were explored in men surviving the North Sea Oil Rig Disaster 27 years ago. In 1980, the survivor population included 75 men. In 2007, 45 survivors remained and completed the Posttraumatic Growth Inventory as part of a larger study. Past predictors were collected by self-reports and interviews done within the first year post disaster, after 1 year and after 5 years.

From the maximum obtainable PTGI score of 105, the survivors had a mean score of 48.4 (SD 20.44), thus reporting modest PTG. Preliminary analyzes indicate positive correlations between PTG levels and concurrent symptom scores, and lower correlations between current PTG reports and past symptom levels. Current and past predictors of symptom levels and personality features will be examined and presented in a long-term perspective.

Reactivation of Posttraumatic Stress in Disaster Survivors
The prevalence of re-occurring episodes of Posttraumatic stress symptoms were studied in 50 disaster survivors in the wake of the North Sea Oil Ring Disaster 27 years ago. The survivors had been assessed by research methods in a longitudinal design with four measure points. Reactivation was assessed retrospectively from the disaster till the follow-up study 27 years later. The evaluation of each case was supported by data collected at 6 months, 1 year, and 5 years after the primary disaster. Reactivation were reported in 18 % (n=9) of the survivors. In six cases (12%), the reactivation fulfilled the *DSM-IV* diagnostic criteria for PTSD. The remaining three cases were sub-syndromal and did not meet the C criterion. All nine cases reached the B criterion. The reported precipitating events which instigated reactivation ranged from minor triggers to full A1 criterion stressors. Posttraumatic bridge symptoms and predictors of reactivation will be explored, and also, some case details will be shared.

Peritraumatic Death Threat as a Long-Term Predictor
Interviews with survivors from the North Sea Oil Rig Disaster were carried out right after the disaster, and again, after 5 and 27 years post trauma. One interview item addressed the perceived peri-traumatic death threat, i.e., how the survivors saw their chances of dying or surviving in the midst of the disaster. Responses to these items remained rather stable over time, and also, they served as

predictors of symptom levels in a short-term and long-term perspective. In addition, the roles played by intermediate variables such as personality and the quality of the childhood environment of the survivors will be presented and discussed.

Living With Rock Slide Risk – People's Communication Needs and Perception of Risk

On the west coast of Norway, about 3000 people are living in a danger zone under the threat of a major rock slide of 40-70 million cubic meters, which may splash into the fjord below and cause a tsunami. Waves estimated up to 40 meters may hit the communities along the fjord. A research project has been initiated to provide answers to two central questions: What factors may make the public comply with evacuation plans? What risk messages seem more effective in meeting the information and communication needs of the public? A similar disaster happened nearby in 1934 and caused 40 deaths. In the analyzes presented, subgroups will be contrasted: those living in areas likely to be hit when a major rock slide occurs, and those living above these sea levels; those with relatives involved in the former rock slide in 1934, and the rest, etc. Moreover, psychosocial data, personality issues and locus of control will be explored in relation to the perceptions of risk, and also, what are the possible implications for mass communication in such situations? An anonymous questionnaire survey was distributed to all 875 people above 18 years living in the communities under threat. A total of 400 questionnaires were returned. Preliminary data will be presented and discussed.

Children Living With Fear: The Effects of War, Terrorism, and Domestic Violence

(Abstract #196297)

Symposium/Panel (Child, Civil Ref) **State Ballroom, 4th Floor**

Weatherill, Robin, PhD[1]; Nyaronga, Dan, PhD[2]; Posada, German, PhD[3]; MacDermid, Shelley, PhD[4]; Kamboukos, Demy, PhD[5]; Hume, Elizabeth, PhD[5]; Cloitre, Marylene, PhD[5]; Dekel, Rachel, PhD[6]; Green, Ohad, BSW[6]; Lavie, Tamar, PhD[7]; Ross, Leslie Anne, PsyD[8]; Larson, Linnea C., MA[8]; Gaba, Rebecca, PhD[8]; Seilicovich, Irma, MFT[9]; Foy, Patrick, BA[8]; *Foy, David W., PhD*[10]

[1]*National Center for PTSD, VA Boston Healthcare, Boston, Massachusetts, USA*
[2]*Military Family Research Institute, Purdue University, West Lafayette, Indiana, USA*
[3]*Child Development and Family Studies, Purdue University, West Lafayette, Indiana, USA*
[4]*College of Consumer and Family Sciences, Purdue University, West Lafayette, Indiana, USA*
[5]*Institute for Trauma and Resilience, NYU Child Study Center, New York, New York, USA*
[6]*The Louis and Gabi Weisfeld School of Social Work, Bar Ilan University, Ramat-Gan, Israel*
[7]*Shaar Hanegev Municipality, Rehovot, Israel*
[8]*Children's Institute, Inc, Los Angeles, California, USA*
[9]*The Village Family Services, North Hollywood, California, USA*
[10]*Graduate School of Education & Psychology, Pepperdine University, Encino, California, USA*

This symposium addresses the effects of domestic and war-related trauma on children. Presentations include data on children affected by domestic violence, parental military deployment, the 9/11 attacks in NYC, and Israeli children who experienced the Second Lebanon War. A treatment model for children exposed to domestic violence will be presented.

Relationships Between Parental Deployment and Child Adjustment in Military Families

Previous studies have shown a relationship between military deployment and children´s well-being (Cozza, Chun, & Polo, 2005) in military families. Young children may be particularly vulnerable to the effects of parents´ military deployment due to their lack of cognitive maturity and dependence on parents for their security. However, to date, few studies of child-parent attachment relationships have been conducted with military samples. Using survey data from 367 English-speaking and Spanish-speaking mothers, this study examines relationships among the frequency, duration, and nature of deployment, parents´ behavior, and children´s behavior, in particular behaviors that may indicate attachment (in)security. Mothers of preschool children (3-5 years old) provided information on the variables of interest. Regression analyses examine whether the nature of military deployment (e.g., combat or non-combat) is related to parents' reports of children´s behavior, over and above the frequency and duration of deployments. Our analyses also investigate the moderating effects of parents´ behavior and control for parents' well-being.

Multiple Traumatization, Psychopathology and Resilience in Children Exposed to the 9/11 World Trade Center Attacks

While it is known that exposure to cumulative trauma greatly heightens children´s risk for PTSD, there is as yet no evidence regarding the possible influence of traumatic stressors on children´s resilience. We evaluated resilience, defined as an absence of symptoms of PTSD, depression and anxiety as well as the presence of normative levels of adaptive functioning among 203 middle-school children living in a largely immigrant community in downtown New York City that were directly exposed to the 9/11/01 attacks on the World Trade Center. Measures of self-reported PTSD (CPSS-SR), functional capacities (BASC-2) and lifetime exposure to traumatic stressor were obtained. Results indicate that among those children exposed to 9/11 who did not experience other traumatic stressors, 68% did not develop any psychiatric symptoms and 58% also maintained normative levels of functioning. However, with every additional traumatic stressor, both presence of psychopathology and risk for problems with adaptive functioning increased significantly. Among children with 3 or more traumatic experiences in addition to 9/11, only 28% were symptom-free and only 18% were both symptom free and functioning at normative levels. The data suggest that cumulative trauma results not only in increasing levels of psychopathology but also in diminishing adaptive capacities.

Emotional Reactions of Israeli Adolescents Following the Second Lebanon War

The current study examined the emotional reactions of Israeli adolescents following the Second Lebanon War and the contribution of gender, level of exposure, earlier traumatic events and relationships with the mother to the variability of these reactions. 3000 adolescents in the ages of 13-14 from the northern parts of Israel participated in the study one year after the war. Participants completed self-report questionnaires assessing socio-demographic background, PTSD, additional psychiatric symptoms, well being and their relations with their mothers (Parental Bonding Instrument). The rate of PTSD among the adolescents was 10%, while the rate of the girls among this group was almost doubled than that of the boys. Subjective fear during the war and earlier traumatic events contributed negatively to emotional reactions. Level of mother's care, as perceived by the child, contributed negatively to emotional reactions, while level of mothers' protectiveness contributed positively. The study highlights the resiliency of these adolescents. In addition, the study identified that gender, level of subjective exposure, earlier traumatic events and relations with the mother and especially protectiveness are risk factor for emotional distress.

Developmental Differences in Self-Reported Domestic Violence Exposure and Posttraumatic Stress Disorder in Children and Adolescents

Research is needed to inform developmentally appropriate assessment and treatment of PTSD in children and adolescents exposed to domestic violence. This study compared self-reported domestic violence exposure and PTSD symptoms between two groups of children representing two developmental stages: young children (ages 5-10, N = 126) and adolescents (ages 11-18, N = 70). Participants completed standardized self-report measures assessing PTSD (Los Angeles Symptom Checklist – LASC – Adolescent Version, and LASC-Child Version), and exposure to

domestic violence (Conflict Tactics Scale - CTS, and CTS – Child Version) as part of the intake process for domestic violence treatment groups. Clinically significant PTSD symptom levels were found in 20.8% of the children and 17.7% of the adolescents, and domestic violence severity was associated with PTSD symptom levels after controlling for other abuse. The top PTSD symptoms reported by the two age groups differed, suggesting developmental differences in PTSD symptomatology. An overview of Children´s Institute´s Group Treatment Model for Domestic Violence will also be presented.

Acute Medical Interventions for Prevention and Treatment of PTSD: Considerations and New Findings

(Abstract #196394)

Symposium/Panel (Bio Med, Clin Res) **Salon 1, 3rd Floor**

Mouthaan, Joanne, MSC[1]; Visser, Rogier, MSC[1]; Gabert, Crystal, BS[2]; van Stegeren, Anda, PhD[3]; *Zatzick, Douglas, MD, PhD*[4]; Olff, Miranda, PhD[1]; Witteveen, Anke, PhD[1]; De Vries, Giel-Jan, MA, MSC[1]; Goslings, Carel, MD, PhD[5]; Sijbrandij, Marit, PhD[1]; Humphrys, Kimberly, RN[6]; Fallon, William, MD[7]; Delahanty, Doug, PhD[8]; Roozendaal, Benno, PhD[9]; Kindt, Merel, PhD[3]; Wolf, Oliver, PhD[10]; Joels, Marian, PhD[11]

[1]Department of Psychiatry, Center for Psychological Trauma, Academic Medical Center, Amsterdam, Netherlands
[2]Kent State University, Ravenna, Ohio, USA
[3]Department of Clinical Psychology & Cognitive Science Center, University of Amsterdam, Amsterdam, Netherlands
[4]University of Washington, Seattle, Washington, USA
[5]Trauma Unit, Department of Surgery, Academic Medical Center, Amsterdam, Netherlands
[6]Division of Trauma, Summa Health System, Akron, Ohio, USA
[7]Summa Health System, Akron, Ohio, USA
[8]Kent State University, Kent, Ohio, USA
[9]Center of Neurobiology of Learning and Memory, University of California, Irvine, California, USA
[10]Faculty of Psychology, Department of Cognitive Psychology, Ruhr-Universität Bochum, Bochum, Germany
[11]SILS-CNS, University of Amsterdam, Amsterdam, Netherlands

There is a growing interest in pharmacological interventions for the prevention and treatment of PTSD, especially because of the need for easily implementable early interventions and the need to accommodate patients who have difficulties completing psychotherapeutic interventions. This symposium presents an overview of current research, and discusses considerations for pharmacological research from a real world perspective.

Acute Medication and Trauma-Related Psychopathology in Level I Trauma Center Patients

After traumatic injury, many patients receive acute medical interventions with pharmacologic agents which could have secondary psychological effects. Some pharmacological compounds (i.e. corticosteroids, beta-adrenergic antagonists) are currently being tested in randomized controlled trials for their preventive effects on PTSD, whereas other frequently prescribed medication (i.e. analgesics) –despite possible psychological effects– is not. In order to inform researchers of the posttraumatic effects of frequently prescribed and administered acute medication, this study focuses on the relationship between real world medication administered to injury patients at a Level I trauma center and subsequent trauma-related psychopathology. As part of a larger prospective study on the incidence and prediction of trauma-related psychopathology in injury patients (called Trauma TIPS), we collected data on prescribed and administered medication of Level I trauma center patients (N=530) within the first 4 weeks post-injury. Trauma-related psychopathology (i.e. PTSD, depressive disorders, anxiety disorders) is assessed at 1 week, 1 month, 6 months and 12 months. The findings of the study will be presented and discussed in terms of possible considerations for secondary prevention of PTSD after injury.

Salivary Cortisol and PTSD Symptom Clusters in Rescue Workers

Although low basal cortisol levels have inconsistently been related to PTSD, current research aims to investigate the inhibiting effects of glucocorticoids on PTSD symptomatology. The results of the current study might add some important findings to this research. Participants (N=1088 rescue workers) were assessed 8.5 years after exposure to the Amsterdam air disaster in 1992. Cortisol from saliva was collected either in the morning, at noon, or afternoon. After controlling for time of sampling and other potential cofounders, cortisol levels of rescue workers with PTSD did not differ from colleagues with no PTSD (Exp(B) = 0.80 (CI 0.53-1.19), p>0.05). Nor was there a difference between subclinical and clinical PTSD patients (Exp(B) = 0.99 (CI 0.57-1.74), p>0.05). When looking at symptom clusters, a significant group effect in the group of rescue workers with (subclinical) PTSD (N=173) on mean cortisol level was found (F(3, 169)= 2.82, p=0.04). Post-hoc analyses indicated that this effect was mainly due to the significantly lower mean cortisol levels in the intrusion cluster across all sampling times (total M=10.8, SD=5.4) compared to the mean cortisol levels in the arousal cluster (total M=14.4, SD=7.1) (p=0.025). Findings will be discussed.

Early Secondary Interventions With Hydrocortisone for In-Hospital Trauma Patients

Secondary pharmacological interventions hold promise for preventing/reducing symptoms of PTSD. However, few randomized trials have examined the efficacy of pharmacological agents. Participants were recruited from a level 1 trauma center within 12-hours post-trauma. Participants were randomized to receive hydrocortisone (20mg bid) or placebo for sixteen days. Symptoms of PTSD and comorbid disorders were assessed 1- and 3-months post-trauma. At 1-month post-trauma, preliminary results have suggested that participants who received hydrocortisone had lower PTSD symptoms (M=28.1, SD=24.7) than those receiving the placebo (M=35.3, SD=22.5), (F(2,14)=2.80, p=.095). Groups differed significantly on hyperarousal symptoms such that hydrocortisone recipients reported lower hyperarousal symptoms (M=7.3, SD=6.2) than those receiving the placebo (M=14.0, SD=11.2), (F(2,14)=6.95, p=.008). Updated findings of this on-going protocol will be presented.

Interaction of Noradrenaline and Cortisol on Brain Activation and Emotional Memory

Stress hormones like noradrenaline and cortisol are released during emotionally arousing events and prepare the body for an effective response to the stressor. Stress within the learning context facilitates encoding of information. Several studies have shown that particularly aversive information is well remembered which can be very disturbing in the case of Posttraumatic memories in patients with PTSD. Animal studies have shown that both the amygdala and hippocampus are involved in these effects of stress, the former particularly in emotionally arousing learning situations. Additionally the prefrontal cortex also plays a role in this process by regulating the emotional arousal process. In humans the role of the noradrenergic and the corticosteroid system separately on memory formation has been established. However, the putative interaction between the two hormonal systems has not been addressed in the human brain yet. In this fMRI study we administered 48 healthy men yohimbine and/or cortisol versus placebo. We demonstrate that central elevations of noradrenaline (induced by yohimbine) and of cortisol in interaction promote the formation of emotional versus neutral memory. The combined drug administration was linked to strong deactivation of the prefrontal cortex during acquisition, as well as reduced activation of the hippocampus and amygdala.

PTSD Clinical Complexity Associated With Co-Occurring Major Depression

(Abstract #196461)

Symposium/Panel (Clin Res, Practice) **Monroe Ballroom, 6th Floor**

Zoellner, Lori, PhD[1]; Bedard, Michele, MS[1]; Jaeger, Jeff, BS[2]; Eftekhari, Afsoon, PhD[3]; Echiverri, Aileen M., BS[4]; Stines Doane, Lisa, PhD[5]; Aguirre McLaughlin, AnnaMaria, MA[6]; Feeny, Norah, PhD[7]; *Rothbaum, Barbara, PhD*[8]

[1]University of Washington, Seattle, Washington, USA
[2]Department of Psychology, University of Washington, Seattle, WA, USA
[3]Palo Alto VA, Palo Alto, California, USA
[4]Department of Psychology, University of Washington, Seattle, Washington, USA
[5]Psychology, Case Western Reserve University, Cleveland, Ohio, USA
[6]Case Western Reserve University, University Heights, Ohio, USA
[7]Case Western Reserve University, Cleveland, Ohio, USA
[8]Emory University, Atlanta, Georgia, USA

How common is the presence of co-occurring major depression (MDD)? How does this co-occurrence affect broader indices of functioning? and, how does it impact the therapeutic process during PTSD-related treatment? In this symposium, we will address these questions. Four talks will be presented. Michele Bedard and colleagues will initially ask the question about the nature of a "pure culture" or "pristine" PTSD, particularly focusing on the co-occurrence of MDD and who are typical patients within a PTSD clinical treatment trial. Aileen Echiverri and colleageus will then examine this impact of co-occurring MDD on psychophysiological indices and general health functioning. We will then shift to discussing the impact of co-occurring MDD on psychotherapy treatment-related processes. Lisa Stines Doane will discuss the potentially deleterious impact of co-occurring MDD on sudden early treatment gains; and finally, AnnaMaria Aguirre McLaughlin will explore the potential impact of co-occurring MDD on therapeutic alliance. Barbara Rothbaum will serve as a discussant, highlighting the clinical implications of co-occurring MDD in terms of understanding the nature of PTSD and its impact during psychotherapy.

Who Seeks Treatment? The Complexity of PTSD in Clinical Trials
Efficacy trials investigating mental health treatments are often criticized for narrow inclusion criteria (e.g., Seligman, 1995; Westen, 2006), lacking generalizability to complex presentations and co-occurring disorders (e.g., major depressive disorder (MDD). With PTSD-related treatment, it has been suggested that these efficacy trials are only more applicable to cases of "pristine" PTSD (e.g., Spinazzola et al., 2005). In the present study, we explore clinical complexity including multiple traumas, childhood trauma, extensive past treatment, and co-occurrence of MDD in a sample seeking treatment for chronic PTSD. Of the 173 men and women, studied a mere 7.1% reported one traumatic event, the majority (57.6%) reported greater than four traumatic events, and a substantial number (61.3%) reported childhood physical and/or sexual abuse (54.9% history; 24.2% index trauma). Furthermore, most received past psychotherapy (78%) or pharmacotherapy (64.2%). The majority of the sample met current criteria for MDD (53.2%), and individuals with co-occurring MDD reported more traumatic experiences (Cohen´s d = .57) and more past pharmacotherapy (Cohen´s d = .55). Thus, samples in research trials may exhibit complex presentations, and the notion of "pristine" PTSD may exist only as a conceptual model, not seen in clinical settings including research trials.

Physical Scars? Co-Occurring PTSD and MDD, Childhood Trauma, Cardiovascular Activity and Physical Health
Increasing evidence from animal and human studies shows that persistent exposure to both early stressors and diagnostic co-occurrence are associated with negative physiological health outcomes (Graham et al., 1999; Bernet & Stein, 1999). In the present series of studies, we examined the impact of both on heart rate and subjective reports of physical health. In Study 1 (n = 147), cardiovascular activity was assessed in 70 men and women with chronic PTSD, 32 trauma-exposed with no PTSD, and 45 health controls using a five-minute electromyogram baseline recording. Individuals with PTSD, regardless of early childhood trauma or co-occurring major depression (MDD), showed elevated heart rate compared to trauma-exposed and healthy controls. In Study 2, using a sample of 173 treatment-seeking individuals with chronic PTSD, neither history of early childhood trauma or co-occurring MDD predicted physical health status above and beyond initial severity or demographic factors. These negative findings raise questions on the additive deleterious effects of early stressors and co-occurrence of MDD, beyond PTSD itself, on subsequent health.

Sudden Gains During Exposure Therapy for PTSD: Does Co-Occurring Depression Matter?
Sudden gains (SG), or large, rapid decreases in symptoms from one session to the next, have been identified across treatments for a range of disorders (e.g., Tang & DeRubeis, 1999; Stines et al., 2008). These SG often account for a large proportion of overall improvement and are consistently related to treatment outcome (Hardy et al., 2005). Given the high rates of co-occurrence between PTSD and depression (MDD), it is possible that those with MDD may evidence a different pattern of symptom improvement during treatment than those without MDD. The present study sought to examine SG among adults receiving prolonged exposure treatment for chronic PTSD (n = 110) and to compare patterns of symptom improvement for those with and without co-occurring MDD. SG were computed following Tang and DeRubeis´ (1999) method. SG occurred for 61% of participants, with a mean magnitude of 11.86 (SD=5.29) points on the PSS-SR (Foa et al., 1997). SG occurred throughout treatment, with 44% by mid-treatment. Further, those with co-occurring MDD (51% of sample) were as likely to experience SG as those without MDD. Presence of SG in treatment may have implications for appropriate treatment duration, course of treatment, and outcome.

Alliance Patterns in Exposure Therapy for PTSD and PTSD Co-Occurring With Depression
Although exposure-based therapy is widely empirically-validated for PTSD little is known about underlying psychotherapeutic processes such as client-therapist alliance. In this growing area of research, stronger early alliance and alliance patterns characterized by the presence of a rupture-repair episode, that is, a decrease in alliance followed by a quick increase to previous level, have been associated with favorable outcome. Employing criteria consistent with prior approaches (e.g., Strauss et al., 2006), participants experiencing a rupture-repair were identified. Of the 78 participants receiving prolonged exposure, 19% experienced a rupture-repair, the presence of which was not significantly different between the two diagnostic groups and not associated with severity of PTSD, depressive, and anxiety symptoms. Further, no differences were found between overall alliance levels between PTSD and PTSD/MDD. A more nuanced understanding of the therapeutic relationship has the potential to assist clinicians in navigating the ups and downs of the alliance, which ultimately may improve treatment outcome by enhancing client commitment and engagement in therapy and client-therapist communication.

Implementation of TF-CBT: A Multi-Cultural Look at Multi-Level Influences From Policy to Fidelity

(Abstract #196438)

Symposium/Panel (Clin Res, Child) **Wabash Room, 3rd Floor**

Berliner, Lucy, MSW[1]; Murray, Laura, PhD[2]; Jensen, Tine K., PhD[3]; *Saunders, Benjamin E., PhD*[4]
[1]Harborview Center for Sexual Assault and Traumatic Stress, Seattle, Washington, USA
[2]Boston University School of Public Health, Boston, Massachusetts, USA
[3]Norwegian Centre for Violence and Traumatic Stress Studies, Oslo, Norway, Norway
[4]Medical University of South Carolina, Charleston, South Carolina, USA

There is an increasing need to research the implementation of evidence based practices, particularly as the interest and political support increases. Various training programs, fidelity measures, supervision support, assessments, and local policies can greatly affect the implementation process. This symposium will highlight the status of implementation research in three areas of the world, in the context of ongoing research projects.

Implementing TF-CBT in the U.S.A.
The United States has seen a surge in state policies mandating the use of EBPs, yet few are trained in them and the implementation process is under-studied. Harborview in Washington state has had extensive experience attempting to implement TF-CBT in real-world, public mental health settings in WA state and British Columbia. This presentation will describe the implementation model (organizational consultation, basic learning session, telephone case consultation, advanced learning session) and lessons learned from successive cohorts. The recruitment and ongoing support for a cadre of local clinical supervisors will be highlighted as a successful strategy for agency wide adoption and diffusion. Experience with assessing competence in TF-CBT skills using selected tape review for the BC cohort will be described. Strategies for overcoming challenges at the organizational and clinician level will be discussed.

Implementing TF-CBT in Zambia
Implementation of evidence-based practices in low-resource settings is severely under-researched, often leading to inadequate or non-existent policies on mental health services. This is a critical dearth in knowledge as many developing countries experience staggering of traumatic events including wars, disease and massive population displacement. This presentation will describe a real-world implementation project being conducted in Lusaka, Zambia using TF-CBT. The identified population is HIV-affected youth that have been sexually abused. Data will be presented on the characteristics of child sexual abuse in Zambia, baseline trauma symptomatology, a training program designed for para-professionals, the supervision structure, case summaries and fidelity checklists. Discussion will include the challenges and successes of implementation in Africa, in addition to a broader perspective on how this work is affected by and should affect mental health policy in low-resource countries.

Implementing TF-CBT in Norway
European countries are not currently mandating the use of EBPs in mental health care, however professional organizations are increasingly encouraging the training in and use of EBPs. This presentation will discuss an ongoing effectiveness study in Norway that is implementing TF-CBT in three child guidance clinics in Norway. Traumatized youth are randomly selected to a treatment as usual group or a TF-CBT group. Lessons learned from recruitment and implementation will be presented, including development of an appropriate training program, fidelity measures, baseline symptoms, and cost-effectiveness design of TF-CBT versus treatment-as-usual. Discussion will include how the European and Norwegian government policies are affecting implementation and use of EBPs, as well as successes of implementation.

A Comparison of African-American and Caucasian Women in Cognitive Behavioral Treatments for PTSD

(Abstract #196116)

Paper Presentation (Cul Div, Clin Res) **Wabash Room, 3rd Floor**

Lester, Kristin, PhD[1]; Artz, Caroline, BS[1]; Resick, Patricia, PhD[1]
[1]Women's Health Sciences Division, National Center for PTSD, Boston, Massachusetts, USA

Race and PTSD treatment is an understudied topic. Two studies suggest that for treatment completers, there are minimal racial differences in outcomes (Rosenheck,1995; Zoellner,1999); however, there are barriers to completion that also warrant attention. This study investigates race and psychotherapy participation among African-American and Caucasian female victims of interpersonal violence in treatment for PTSD. Study 1 consisted of 171 women randomized into cognitive processing therapy (CPT), prolonged exposure (PE), or a wait-list condition. In Study 2, 150 women were randomized into 3 conditions: CPT, cognitive therapy (CPT-C) and written account (WA). Results of study 1 revealed that African-Americans compared to Caucasians had higher drop-out rates (33% vs. 15%, respectively, p=.007) and lower percentage of session completion (58% vs. 86%, respectively, p<.001). Study 1 indicated a trend towards higher African-American participant drop-out in PE. Study 2 revealed a trend toward African-Americans completing fewer percentage sessions than Caucasians. Regression analyses indicated that although race was a significant predictor of higher session completion, other variables (e.g., employment, income and education) contributed to the model, suggesting the relevance of factors in addition to race. We will also present PTSD outcome data from intent to treat samples.

Understanding and Treating Anger in Canadian Forces Members and Veterans With Military Related PTSD

(Abstract #196322)

Workshop/Case Presentation (Practice, Mil Emer) **Salon 2, 3rd Floor**

Smith, Wanda, PhD[1]; Richardson, Don, MD[2]
[1]McMaster University, Hamilton, Ontario, Canada
[2]Operational Stress Injury Clinic, Parkwood Hospital, London, Ontario, Canada

Canada´s military involvement in Afghanistan and peacemaking initiatives has resulted in troops with trauma disorders. Research has enhanced understanding of PTSD identifying empirically validated treatments and highlighting co-morbidity of other disorders such as depression and substance abuse. Of growing interest is the relationship between PTSD and anger in the military population. Research has highlighted the rates of anger, hostility and aggression in military populations with PTSD and identified that anger is a negative predictor of treatment. Further, it is suggested that anger be considered independent from PTSD and may need to be treated separately from the disorder. Anger management training is well established however, the unique features of this population, namely military training and deployment experiences and the fear of physically hurting others often necessitates further treatments. The purpose of the proposed workshop is to describe the treatments for anger provided collaboratively by psychiatry and psychology to Canadian Forces members and veterans with PTSD. The treatment includes pharmacologic interventions, anxiety management training, cognitive behaviour therapy and behavioural rehearsal. The presentation will detail therapy for anger utilising case studies and reporting standardized rating scales, behavioural logs and quality of life scales.

Concurrent Session 6
Friday, November 14
9:30 a.m. – 10:45 a.m.

DSM-V
Why are Some People More Likely to Get PTSD Than Others?

Child and Adolescent Traumatic Stress and PTSD: A Developmental Perspective

(Abstract #198301)

DSM-V (Asses Dx, Child) **Grand Ballroom, 4th Floor**

Pynoos, Robert, MD, PhD[1]; Fairbank, John A., PhD[2]; Steinberg, Alan, PhD[1]
[1]University of California, Los Angeles, Los Angeles, California, USA
[2]Duke University, Durham, North Carolina, USA

The diagnostic category of PTSD has permitted our field to give scientific voice to the legacy of trauma for children and adolescents. It has also provided an important opportunity for the developmental investigation of its strengths and limitations, and consideration of treatment implications and testing of intervention strategies across developmental stages. Adopting a developmental perspective in further strengthening the diagnosis will provide an important vantage point on the following issues: 1) the theoretical and conceptual framework underlying PTSD, making use of new knowledge in developmental neurobiology and genetics; 2) the evolving appraisal and response to danger; 3) the construct and factor analysis of PTSD, especially in regard to symptom profile; 4) the role of associated intense negative emotions, for example, shame and guilt; 5) the role of ongoing preoccupation with protection and intervention thoughts; 6) co-morbid considerations, including the intersection of childhood PTSD with anxiety disorders and depression; and 7) the interplay with disturbances in developmental competencies. There is a critical need to complement assessment of functional impairment with equal attention to developmental impairment, including trauma-related disturbances in achieving developmental competencies and reaching developmental milestones. In addition, children are at risk of exposure to traumatic losses that require assessment of a range of traumatic grief reactions and their intersection with posttraumatic stress reactions and co-morbid conditions. Overall, prior *DSM* criteria have given only limited attention to developmental considerations which need to have a much more prominent place in *DSM V*. Selected findings from the National Child Traumatic Stress Network Core Data Set that relate to these challenges will be included in this presentation.

Gene-Environment Interaction in Posttraumatic Stress Disorder

(Abstract #197569)

DSM-V (Bio Med, Res Meth) **Grand Ballroom, 4th Floor**

Koenen, Karestan, PhD[1]
[1]Department of Society, Human Development, Harvard University School of Public Health, Boston, Massachusetts, USA

The purpose of this presentation is to encourage research investigating the role of measured gene-environment interaction (GxE) in the etiology of posttraumatic stress disorder (PTSD). PTSD is uniquely suited to the study of GxE as the diagnosis requires exposure to a potentially-traumatic life event. PTSD is also moderately heritable; however, the role of genetic factors in PTSD etiology has been largely neglected both by trauma researchers and psychiatric geneticists. First, we summarize evidence for genetic influences on PTSD from family, twin, and molecular genetic studies. Second, we discuss the key challenges in GxE studies of PTSD and offer practical strategies for addressing these challenges and for discovering replicable GxE for PTSD. Finally, we propose some promising new directions for PTSD GxE research. We suggest that GxE research in PTSD is essential to understanding vulnerability and resilience following exposure to a traumatic event.

Epigenetics and PTSD: A New Frontier in PTSD Risk and Implications for *DSM-V*

(Abstract #198156)

DSM-V (Bio Med, Asses Dx) **Grand Ballroom, 4th Floor**

Yehuda, Rachel, PhD[1]
[1]Mount Sinai School of Medicine Medical School, Bronx, New York, USA

The study of epigenetic modifications of DNA may provide important insights into PTSD risk and pathophsiology since it provides a mechanism for explaining functional changes in genomic activity (as opposed to structural changes associated with different allelic variations or gene polymorphisms) that can be induced by environmental events. These functional changes can even be transmitted intergenerationally (e.g., via maternal behavior) which may provide critical insight for why PTSD runs in families. Indeed, when considering that PTSD is fundamentally a response to an environmenal event that is likely formed, not so much by the objective characteristics of the event, but by subjective interpretations of its meaning, it becomes obvious that neither genetic analysis alone, nor an understanding of the nromative biological responses to stress or fear, can provide the information that explains why PTSD results in only a proportion of those exposed. The study of epigenetics may, in particular, provide a relatively stable measure that reflects early life events, rather than the cumulative effects of stress, that can help delineate developmental influences on biological alterations in PTSD from those relfecting pathophysiology. The implications for epigenetic contributiions to diagnostic issues in PTSD will be discussed.

Diagnostic Overlap Between PTSD and MDE in Two American Indian Populations: Implications for *DSM-V*

(Abstract #197567)

DSM-V (Asses Dx, Cul Div) **Grand Ballroom, 4th Floor**

Beals, Janette, PhD[1]
[1]University of Colorado - Denver, American Indiana and Alaska Native Programs, Aurora, Colorado, USA

Psychiatric epidemiology has come of age in the past 30 years. Landmark studies have provided for essential descriptions of the prevalence of common *DSM*-defined disorders, including PTSD. Yet, parallel efforts for important subpopulations have laggEd, resulting not only in a dearth of data about groups that may be at special risk, but also neglecting an opportunity to examine the consequences for our common nosologies in culturally diverse settings. The American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project (AI-SUPERPFP) was designed to assess the epidemiology of common mental health problems in two culturally diverse American Indian tribal groups using state-of-the-art methods. Perhaps the most interesting finding from this effort was a "crossover" between PTSD and major depressive episode (MDE) in the lay-administered interviews, whereby PTSD was found to be more common than in the general U.S. population, yet MDE was less common. At the same time, when clinicians interviewed a subset of those in the lay-administered sample, the pattern of findings was reversed (MDE more common than PTSD). In this presentation we will explore the implications of these findings for both *DSM-V*, generally, and for psychiatric epidemiology, in particular.

All the Way Home – A Documentary Film

(Abstract #196452)

Media Presentation **Salons 4-6, 3rd Floor**

Buchen, Charlotte, MA[1]; Caine, Julie, MA[1]
[1]University of California, Berkeley, Berkeley, California, USA

This is the story of coming home from war told through the eyes of veterans, and their families—conveying the flashbacks and paranoia that continue to plague them long after the battle is over.

Giving context are interviews with Dr. Barbara Rothbaum and Dr. Albert "Skip" Rizzo and a short history of Posttraumatic Stress Disorder- from Homer's time, to the Civil War and "soldier's heart," to the "shell shock" of WWI, up to the current diagnosis of PTSD.

Sunny San Diego is a far cry from war-torn Iraq, and Jeff Stinchcomb never thought the war would follow him home. But it did.

Driving on San Diego's freeways was a challenge. Trash on the side of the road evoked roadside bombs. His daughter's three-year-old tantrums threw him into a rage.

Also guiding us through the story is Vietnam veteran, Steve Campbell who 35 years after the war ended still struggles with rage and anxiety. Steve has made it his mission to make sure the Iraq veterans don't go through the trauma that he experienced, untreated for so long.

Steve and Jeff are friends, in the same therapy group.

The film draws no conclusions about whether Jeff will ever be the man he was before he went to war, but rather presents his story through his words, allowing audiences to draw their own conclusions about how the war comes home.

Participant Alert: Caution – this film includes some graphic images of war as well as potentially disturbing stories about war-time experiences.

Complex Trauma in Children and Adolescents: Treatment Needs and Methods

(Abstract #196053)

Symposium/Panel (Child, Practice) **State Ballroom, 4th Floor**

Fletcher, Kenneth, PhD[1]; Nader, Kathleen, DSW[2]; Stolbach, Bradley, PhD[3]; Cloitre, Marylene, PhD[4]; DeRosa, Ruth, PhD[5]; Saxe, Glenn, MD[6]; *Ford, Julian, PhD*[7]
[1]Psychiatry, Center for Mental Health Services Research, University of Massachusetts Medical School (Worcester), Worcester, Massachusetts, USA
[2]Director, Two Suns, For the Assistance of Traumatized Children and Adolescents, Cedar Park, Texas, USA
[3]Behavioral Sciences, La Rabida Children's Hospital / University of Chicago, Chicago, Illinois, USA
[4]Psychiatry, Institute for Trauma and Resilience, NYU Child Study Center, New York, New York, USA
[5]Cognitive Behavioral Associates, Great Neck, New York, USA
[6]Psychiatry, Children's Hospital Boston, Boston, Massachusetts, USA
[7]Psychiatry, University of Connecticut Health Center, Farmington, Connecticut, USA

Researchers/clinicians will discuss important questions facing the field regarding the treatment of complex trauma in childhood (or Developmental Trauma Disorder). Panel members will discuss various important issues that arise when treating children and adolescents who have experienced chronic interpersonal violence.

Is Trauma-Focused Narrative Work an Essential Component of Complex Trauma-Focused Treatment?
Stolbach, Bradley

Increasing attention has focused on the effects of complex trauma in childhood. Recognition of the limitations of PTSD as an explanatory diagnostic model for the developmental impairments and adaptations displayed by children with complex trauma histories has correctly led to the development and promotion of treatments that emphasize domains such as attachment, self-regulation, developmental competencies, and body work over widely accepted "evidence-based" simple PTSD treatments. Many symptoms, whether related to simple or complex trauma, arise and persist as a result of a failure to integrate overwhelming experience. In developing treatment approaches that highlight the need to address symptom domains that most characterize children with complex developmental trauma disorders, clinicians should be wary of minimizing the central role that trauma integration plays in healing, and thus inadvertently reinforcing our clients' and our own tendencies to avoid traumatic content in treatment. A treatment approach will be described that attempts to integrate a complex trauma intervention framework with trauma-focused therapy. The question of whether trauma-focused narrative integrative work should be viewed as an essential component of effective treatments for children with developmental trauma disorders will be addressed.

How Can Treatment Identify, Address and Resolve the Adverse Impact of Trauma on Development Among Traumatized Adolescents?
Cloitre, Marylene

Recent studies have established that adolescence is the period in life in which exposure to trauma is at its peak. It is also clear that by even the most conservative assessment standards, i.e., using the *DSM-IV* diagnoses, trauma produces a multiplicity of mental health problems and comorbidity is the rule rather than the exception, particularly in regards to the concurrent presence of PTSD, depression and substance abuse. There is growing evidence of the long-term effects of trauma on adolescents´ continued socio-emotional development and of its impact on the brain maturation processes that relate to the capacity for modulation of emotions, control over impulses, and addiction sensitivity. Thus, adolescence is a time of tremendous risk for multiple negative outcomes. This presentation will present the rationale for and training in an adolescent program which targets three central problem domains among adolescents: PTSD symptoms, emotion regulation problems and interpersonal and behavioral functioning. We will also highlight the importance of prevention programming in the preteen and middle school years to avert the various risk factors that lead to increased risk for trauma exposure during adolescence.

What Are the Essential Components for Complex Trauma Treatment With Adolescents?
DeRosa, Ruth

Like both younger children and adults, adolescents with histories of chronic interpersonal violence often struggle with domains of functioning in ways that stem beyond symptoms of anxiety, depression and Posttraumatic stress disorder. The trauma literature has described these common clinical presentations under a number of labels over the years, which include difficulties with regulating affect and impulses, hopelessness, problems with concentration and dissociation, somatization and physical heath, and alterations in attachment, interpersonal relationships, and self-perception. Although there are some similarities across age groups, what are the treatment needs unique to adolescents who have experienced ongoing extreme stress? Vulnerabilities inherent in adolescent development increase significantly in the face of chronic trauma.

This presentation will highlight some approaches to treatment and engagement with chronically traumatized adolescents that focus on specific developmental tasks and demands including establishing independence, relationships, identity, and purpose and meaning in life.

What Processes Need to be Considered in Order for Effective Treatments to Take Hold in the "Real World"?
Saxe, G.

This presentation will focus on the issue of providing effective interventions and services for children with Complex Trauma in the social environments and services systems where these children usually receive care. The discussion will address the following question: What processes need to be considered in order for effective treatments to take hold in the `real world´? Children with Complex Trauma frequently live in environments with ongoing stresses such as family and community violence, parental mental health and substance abuse, and poverty and homelessness.

Further, these children have problems that cross systems of care and can involve the mental health, educational, social service and juvenile justice systems. Treatments developed for children with Complex Trauma must conform to how interventions and services are paid for by the agencies that provide this care. Each of these issues must be thoroughly considered as our field endorses interventions that `work´. This presentation details these issues and proposes ideas for how they can be considered in the process of treatment development. The presenter will use experiences developing the treatment model Trauma Systems Therapy to illustrate how these processes can be considered in the development of a treatment designed to help children with Complex Trauma.

PTSD and the Khmer Rouge Trials in Cambodia

(Abstract #196475)

Paper Presentation (Civil Ref, Commun) **Crystal Room, 3rd Floor**

Sonis, Jeffrey, MD, MPH[1]; Gibson, James, PhD[2]; de Jong, Joop, MD, PhD[3]; Field, Nigel, PhD[4]; Hean, Sokhom, PhD[5]
[1]Social Medicine, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina, USA
[2]Washington University in St. Louis, Saint Louis, Missouri, USA
[3]GGD Amsterdam, Amsterdam, North Holland, Netherlands
[4]Pacific Graduate School of Psychology, Palo Alto, California, USA
[5]Centre for Advanced Study, Phnom Penh, Cambodia

Background: Cambodians suffered profound trauma during the reign of the Khmer Rouge. After years of impunity for the leaders, a joint United Nations-Cambodian tribunal ("the Khmer Rouge trials"), is expected to begin public trials in 2008. The goals of this study were to identify the correlates of PTSD, focusing on desire for revenge and perceived justice and to identify attitudes towards the trials.

Methods: We conducted a national face-to-face interview survey of 1,017 adult Cambodians in 2007.

Results: The prevalence of current PTSD was 10.7%. Desire for revenge was directly, but weakly, associated With PTSD (adjusted odds ratio [aOR], 1.80; 95% CI, 0.94-3.43) and perceived justice for violations during the Khmer Rouge era was inversely associated With PTSD (aOR, 0.47, 95% CI, 0.30 – 0.74). Despite positive attitudes for the trials, 81% of those over the age of 35 believed that the trials will create painful memories for them. Positive attitudes toward the trials were inversely associated With desire for revenge (aOR, 0.75, 95% CI, 0.57-0.99).

Conclusion: The Khmer Rouge trials may be able to reduce PTSD prevalence by increasing feelings of justice and reducing the desire for revenge. However, since most Cambodians believed that the trials will re-awaken painful memories, the trials might increase the prevalence of PTSD. Longitudinal research is needed.

Posttraumatic Stress and Refugee Status Decision-Making

(Abstract #196224)

Symposium/Panel (Civil Ref, Sos Ethic) **Crystal Room, 3rd Floor**

Herlihy, Jane, MPHIL, DCLINPSYCH[1]; Cleveland, Janet, LLB, MSC, PhD[2]; Steel, Zachary, MPSYCHOL(CLINICAL)[3]
[1]Centre for the Study of Emotion and Law, London, United Kingdom
[2]Canada Research Chair in International Migration Law, Universite de Montreal, Montreal, Quebec, Canada
[3]Centre for Population Mental Health Research, School of Psychiatry, University New South Wales, Liverpool, New South Wales, Australia

To claim asylum, refugees must describe their experiences of persecution. Emergent research shows a lack of understanding of trauma in this process. The presenters will bring data from different refugee-receiving countries demonstrating issues with assessing asylum claims that are systematically discriminating against those with the psychological sequelae of trauma.

Asylum Seekers With Posttraumatic Symptoms Facing the Canadian Refugee Determination Process
Many asylum seekers have trauma-related mental health difficulties such as PTSD and depression linked to torture, rape, or other forms of organized violence, often aggravated by post-migration stressors. to be accepted as refugees, asylum seekers must convince immigration officials that they would be at risk if repatriated, largely based on their account of past persecution. Trauma-related symptoms may negatively impact claimants´ ability to credibly present their case because of memory lapses, confusion about details, emotional numbing, etc. This study examines how Canada's immigration system deals with asylum seekers with trauma-related symptoms through qualitative analysis of three types of data: 1) 120 refugee status decisions in cases involving mental health evidence; 2) focus groups with clinicians, lawyers, NGOs and immigration officials on addressing the needs of asylum seekers with mental health problems, and 3) interviews with asylum seekers on their experience of the Canadian refugee system. The study highlights a number of systemic problems, including the tendency of many decision makers to discount expert reports; decision makers´ limited understanding of psychological issues, mirrored by clinicians´ limited understanding of legal issues; and the unduly negative impact of refugee determination proceedings on claimants with mental health difficulties.

Refugee Decision-Making and the Tortured Asylum Seeker—Outcomes Amongst Recently Arrived Asylum Seekers in Australia
There are ongoing concerns that asylum seekers who have been tortured and who suffer trauma-related mental disorders are being refused protection by countries in which they seek asylum. The study described here assessed a consecutive sample of recently arrived asylum seekers attending immigration agents in Sydney, Australia, using a series of structured measures. Participants were followed up to assess the outcomes of their refugee applications. The 73 participants, who had resided in Australia for an average of 4.3 months, reported high rates of torture, and were at heightened risk of PTSD and major depression, a response pattern associated with substantial levels of psychosocial disability. Neither past torture nor current psychiatric disorder influenced the outcomes of refugee applications. The study examines some of the factors that were associated with poor refugee determination outcomes for tortured asylum seekers and others with trauma-related mental disorder.

Assumptions Underlying Refugee Status Decisions in the UK—A Qualitative Analysis
Previous research has highlighted assumptions being made by decision makers in the process of recognising refugees under the 1951 Geneva Convention. For example, late or non-disclosure of difficult personal history is often held to suggest that the individual is fabricating a story at a late stage of their asylum claim; inconsistencies between different versions of a person´s story are believed to show that the account is untrue. These assumptions

do not fit with what we know about how people present accounts of traumatic experiences. In the UK, immigration judges write a full justification of each decision they make in the asylum appeal court. We developed a coding framework and extracted different categories of assumptions from a series of written determinations. These data (117 extracts) were subjected to an inductive (data-driven) thematic analysis. The resultant major themes demonstrated that judges make decisions about 1) the behaviour of individuals and families following experiences of trauma, 2) the behaviour of people seeking asylum and 3) the nature of a truthful account, often incognisant of the nature of traumatic memory. These results will drive future hypothesis-led investigations to establish whether such lay assumptions are consistent with the scientific and clinical literature.

Disaster Mental Health and Older Adults: Implications for Research, Practice and Policy

(Abstract #196048)

Symposium/Panel (Disaster, Sos Ethic) **Salon 3, 3rd Floor**

Cook, Joan, PhD[1]; Brown, Lisa, PhD[2]; Elmore, Diane, PhD, MPH[3]; *Norris, Fran, PhD*[4]; Tashakkori, Abbas, PhD[5]; Bryant, Carol, PhD[6]
[1]Department of Psychiatry, Yale University School of Medicine, West Haven, Connecticut, USA
[2]Department of Aging and Mental Health, University of South Florida, Tampa, Florida, USA
[3]Public Interest Government Relations Office, American Psychological Association, Washington, District of Columbia, USA
[4]VA Regional Medical Center MS 116D, National Center for PTSD, White River Junction, Vermont, USA
[5]Department of Educational & Psychological Studies, Florida International University, Miami, Florida, USA
[6]University of South Florida, Tampa, Florida, USA

Natural disasters and acts of terrorism are increasingly important public health challenges. Growing attention has focused on potentially vulnerable subgroups during such events, including older adults. This presentation will discuss key research, practice and policy issues related to the mental health of older adults in the aftermath of disasters.

State of the Evidence: Older Adults' Disaster Mental Health Responses
Disasters can have considerable mental health effects for a significant proportion of survivors. The purpose of this presentation is to briefly review research regarding mental health consequences of natural, human-made, and technological disasters in older adults. Risk and protective factors for mental health vulnerability will be presented, and subgroups of older adults at particular risk will be highlighted. Implications for future research will also be discussed.

Despite methodological limitations of available research, there appears to be no differential vulnerability on the part of the general older adult population as compared with younger adults. Though age per se does not appear to be the determining factor in risk or vulnerability, age can interact with other social, economic, cultural, and historical factors to influence mental health responses. People of low socioeconomic status, individuals with physical and mental disabilities, ethnic minorities, and those residing in nursing homes or independent living facilities appear to be the most at risk. While the general older adult population may serve as untapped resources in helping to provide a variety of disaster-related services (e.g., community canvassing, house sitting, and meal preparation), those at risk should not be minimized or left to fend for themselves.

Meeting the Mental Health Needs of Elders After Disasters
Review of the Florida disaster crisis counseling programs conducted after the 2004 and 2005 hurricanes revealed that many older adults did not use services despite evidence of ongoing disaster-related psychological distress. It is not clear if older adults who survived the hurricanes experienced unique barriers to treatment. While institutional, clinical, and personal barriers to care for late-life psychological disorders have been well documented, only recently has research begun to focus on issues related to access and use of disaster mental health services in this population. This presentation will discuss the application of a mixed methods approach to examine factors influencing use of disaster crisis counseling services by older adults who were adversely affected by the hurricanes (users n=91 and non-user n=147). Quantitative results indicate that a protracted recovery period adversely affects well-being, yet use of services is not commensurate with self-reported distress. Qualitative findings suggest that older adults who would benefit from intervention may not self-identify as having a mental health problem and thus refrain from seeking or accepting treatment. Traditional models of mental health service delivery and outreach may not be appropriate when the task is to provide care to older adults survivors of disasters.

The Role of Public Policy in Addressing the Needs of Older Adults During Disasters
A series of significant natural disasters and acts of terrorism in recent years have helped to focus the attention of scientists, clinicians, the public, and policy makers on issues of disaster preparedness and response. Among the preparedness and response issues of particular importance is the need to understand and address the impact of such events on the mental health of an increasingly diverse population, including the growing subgroup of older adults. While some important efforts have been made to improve federal disaster preparedness and response policies aimed at older adults, a great deal of work remains to ensure the mental health and well being of the aging population during disasters.

This presentation will identify existing federal emergency and disaster preparedness and response policies of importance to older adults. In addition, newly proposed federal legislation to address the needs of potentially vulnerable subgroups, including older adults and their caregivers, will be discussed. Opportunities for mental health professionals to use research and clinical expertise to inform the federal policy making process related to disaster mental health preparedness and response will also be highlighted.

First Responders: Recovery From Terrorist Attacks and Other Critical Incidents

(Abstract #196290)

Symposium/Panel (Mil Emer, Prev El) **Wabash Room, 3rd Floor**

***Neylan, Thomas, MD*[1]; Halpern, Janice, MD[2]; Wild, Jennifer, DCLINPSY[3]; Gurevich, Maria, PhD[4]; Baum, Naomi, PhD[5]; Maunder, Robert, MD[6]; Schwartz, Brian, MD[7]; Handley, Rachel, DCLINPSY[8]; Brazeau, Paulette, MA, MED[9]; Defina, Piera, BSW[4]; Levaot, Yael, BA, BSW[5]**
[1]Psychiatry, University of California San Francisco, San Francisco, California, USA
[2]Psychiatry, University of Toronto, Toronto, Ontario, Canada
[3]Institute of Psychiatry, King's College, University of London, London, United Kingdom
[4]Psychology, Ryerson University, Toronto, Ontario, Canada
[5]Israel Centre for Psychotrauma, Herzog Hospital, Jerusalem, Israel
[6]Psychiatry, Mt. Sinai Hospital, Toronto, Ontario, Canada
[7]Sunnybrook Osler Centre for Pre-hospital Care, Sunnybrook Health Sciences Centre, Toronto, Ontario, Canada
[8]Institute of Psychiatry, King's College London, London, United Kingdom
[9]University of Toronto, Toronto, Ontario, Canada

This international symposium presents studies of large samples of first responders exposed to terror in globally traumatic events: SARS in toronto, the London bombings of 7 July, and terrorist bombings in Jerusalem. The studies identify key predictors of PTSD, depression, resilience, and response to intervention, in this at-risk group.

Trauma in Paramedics: A Survey of Key Factors Affecting Psychological Outcomes
Objectives: Research suggests that perception of high arousal after trauma exposure is a key predictor of PTSD. We investigated the relationship of duration of arousal to PTSD, depression, burnout and somatisation in paramedics.

Methods: 220 paramedics completed surveys to assess PTSD, burnout, depression, and somatisation. They also completed measures of time for arousal to return to baseline after exposure to critical incidents. Post-incident support and perception of overall workplace stress were also assessed.

Results: Perceived recovery from arousal was associated with outcome. Those who reported longer duration of arousal after trauma had higher PTSD, depression, burnout, and somatisation scores. Perceived workplace stress was also associated with higher scores on all outcomes. Downtime after critical incidents was associated with lower depression and somatisation scores. Contact with others within 24 hours of an incident was associated with lower somatisation scores.

Conclusions: These data suggest that faster recovery from arousal and lower chronic work stress are associated with good health outcomes in ambulance workers. Downtime and supportive contact are also important. Developing evidence-based interventions to reduce arousal and chronic work stress, as well as provision of specific post-incident workplace supports, would benefit this at-risk group.

Paramedics Exposed to the London Bombings of 7 July: A Prospective Study Investigating Cognitive and Neuropsychological Predictors of PTSD
Objectives: Ambulance workers frequently encounter traumatic events and many suffer unwanted memories of them. This study examined the relationship between cognitive responses to intrusions, working memory capacity and traumatic stress in paramedics.

Method: Ambulance workers (N=68) were assessed for working memory capacity using the OSPAN (Turner & Engle, 1989). Intellectual functioning, PTSD, frequency of and responses to intrusions, depression, anxiety, trauma exposure, length of time in service, and alcohol and drug use were also assessed. PTSD was re-evaluated at six months and two years after the London bombings.

Results: Participants with low working memory had higher PTSD scores compared to participants with high working memory. Cognitive responses to intrusions, specifically negative interpretations and avoidance, predicted PTSD status at both follow-up time points.

Conclusions: The results suggest that ambulance workers with PTSD are more likely to have low working memory capacity than those without PTSD. It appears that low working memory capacity is not a risk factor for PTSD but could be affected once PTSD is established. The strongest predictors of PTSD were cognitive responses to intrusions: avoiding them or interpreting them negatively. These results have implications for existing models of PTSD and for pathways of prevention in emergency services.

Emergency Medical Dispatchers Rally Resources to Combat Stress
Objectives: The role of emergency medical dispatchers (EMDs) is critical to the outcome of emergency calls for help. They are the first point of entry for emergency calls; they act as conduit for information between civilians and emergency workers; and may administer limited interventions via telephone. However, their experiences have been virtually ignored. This is the first study to focus on critical incidents experienced by EMDs and to identify their coping strategies.

Method: Semi-structured interviews and focus groups were conducted with EMDs to explore how they define critical incidents and key coping strategies.

Results: EMDs use similar criteria to paramedics to designate calls as critical incidents (e.g., personally relevant or gruesome events). While the personal strategies they use in recovering center on solitary activities (e.g., alone time during a shift, distracting activities, leaving work at work), the professional resources focus on peer and supervisor support. Notably, supervisor support was positioned as central to recovery, while its absence was described as exacerbating.

Conclusions: This is the first study to highlight the impact of critical incidents on EMDs and parallels research with other emergency communications workers, as well as paramedics. Implications for evidence-based interventions will be described.

Building Personal and Professional Resilience
This presentation will focus on our resilience building model "Building Personal and Professional Resilience" which has been adapted from initial work with educators and classrooms. The purpose of this intervention is to train police officers in understanding sources of stress in their lives, and what they can do to alleviate this, increase coping and build resilience. We piloted this intervention on an initial group of 220 police officers from bomb disposal units in Israel who have been highly and consistently exposed to trauma during their professional careers. We will present the resilience model and it's application to work with police. The model focusing on: Self, Strengths, Support and Significance, includes units of psychoeducation, skill development and and emphasis on building social supports within the professional work group. Initial evaluation data will be presented indicating that police officers experienced growth and change as the result of this intervention.The challenges and applicability of resilience building intervention programs with first responder groups will be discussed.

Studying the Phenomenology of PTSD in Groups and Individuals: What Can It Tell Us?

(Abstract #196464)

Symposium/Panel (Asses Dx, Res Meth) **Monroe Ballroom, 6th Floor**

Lauterbach, Dean, PhD[1]; Orazem, Robert, BS[2]; Hebenstreit, Claire, BS[3]; King, Daniel, PhD[4]; King, Lynda, PhD[5]; Shalev, Arieh, PhD[6]; *Palmieri, Patrick, PhD*[7]; Mason, Shawn T., PhD[8]; Fauerbach, James, PhD[9]; Eve, Carlson, PhD[10]; Field, Nigel, PhD[11]; Ruzek, Josef, PhD[12]; Spain, David, MD[13]
[1]Psychology, Eastern Michigan University, Ypsilanti, Michigan, USA
[2]Boston University, Roslindale, Massachusetts, USA
[3]University of Denver, Denver, Colorado, USA
[4]National Center for Posttraumatic Stress Disorder, Boston, Massachusetts, USA
[5]Boston University, Boston, Massachusetts, USA
[6]Center for Traumatic Stress and the Department of Psychiatry, Hadassah University Hospital, Jerusalem, Israel
[7]Center for the Treatment and Study of Traumatic Stress, Akron, Ohio, USA
[8]Johns Hopkins Department of Psychiatry, Johns Hopkins University School of Medicine, Baltimore, Maryland, USA
[9]Johns Hopkins, Baltimore, Maryland, USA
[10]Palo Alto VA Health Care System, Menlo Park, California, USA
[11]Pacific Graduate School of Psychology, Palo Alto, California, USA
[12]National Center for PTSD, Palo Alto, California, USA
[13]Surgery & Critical Care, Stanford University School of Medicine, Stanford, California, USA

There is a broad array of measures to assess PTSD. However, the factorial invariance of these measures across time and groups is often assumed but untested. Moreover, the relationship between these structures and the phenomenology of PTSD is poorly understood. This symposium addresses these issues with an eye toward *DSM-V.*

Factor Structure of the Impact of Event Scale-Revised: Stability Across Cultures and Time
The Impact of Event Scale-Revised (IES-R; Weiss & Marmar, 1997) is a 22-item self-report measure of symptoms frequently endorsed following a stressor. The IES-R is a revised version of the IES (Horowitz et al., 1979). The most significant revisions (i.e., addition of six hyperarousal items and one reexperiencing item) resulted in a measure assessing all three *DSM-IV* PTSD symptom clusters. A

sample of US college students completed an English version of the IES-R, and an Israeli emergency room sample completed a Hebrew-language version on up to three occasions following the emergency room admission. to examine the IES-R´s factor structure and structural invariance over samples and time, seven models initially were evaluated within each sample, and the best-fitting models for each sample was identified. Next, the number of factors and pattern of loadings for the pairs of solutions were examined to assess degree of invariance across samples. The best-fitting models conforming to configural invariance were extensions of the King et al. (1998) "numbing" model and the Simms et al. (2002) "dysphoria" model, with an additional sleep disturbance factor. When invariance over time for the longitudinal data was evaluated, configural invariance was obtainEd, metric invariance was upheld for all factors except reexperiencing.

PTSD Symptom Structure is Reasonably Invariant Across Comorbid Depression Status
PTSD factor analytic research has yielded little support for the *DSM-IV* 3-factor model of re-experiencing, avoidance, and hyperarousal symptoms, while providing little consensus on the best alternative conceptualization. Empirical evidence, however, has tended to favor one of two 4-factor models that include either an emotional numbing factor (King et al., 1998) or a dysphoria factor (Simms et al., 2002), along with the three current *DSM* factors. Differences in sample composition across studies might explain some of the discrepant findings. One such sample difference that is important to study is the degree of comorbid depression, given that depression commonly co-occurs with PTSD, and the two 4-factor models conceptualize depression-related symptoms somewhat differently. In the present study, confirmatory factor analysis of PTSD Symptom Scale data from several trauma-exposed samples was used to test several plausible structural models and invariance across groups defined by comorbid depression status. The emotional numbing and dysphoria models both fit the data well and outperformed the *DSM* 3-factor model and other models. Both also demonstrated reasonable invariance across groups, suggesting that the relationships among PTSD symptoms do not differ substantially based on the presence or absence of comorbid depression. Clinical and nosological implications will be discussed.

Confirmatory Factor Analysis and Invariance of the Davidson Trauma Scale in a Longitudinal Sample of Burn Patients
The Davidson Trauma Scale (DTS), a self-rating scale for assessing posttraumatic stress symptoms (Davidson et al., 1997), was used to assess symptoms in a burn population. Although the DTS has been used in many studies, none have examined the factorial and metric invariance of this measure across time. The current study addresses this issue. Data were collected at a regional burn center and patients were consented based on burn severity (total burn surface area=14%). The 268 participants were primarily male (70%) and Caucasian (68%), with a mean age of 41 years. In the PTSD literature two, four-factor models are commonly supported over the *DSM-IV* three-factor structure. One is characterized by a splitting PTSD cluster C symptoms into avoidance and numbing symptoms (King et al., 1998). The other is characterized by a combination of items from PTSD symptom clusters C and D, forming a dysphoria factor (Simms et al., 2002). CFA results were most supportive of a first order, four-factor, oblique model consistent with the King et al., numbing model at one month post discharge. Invariance of this factor structure was assessed at 6 and 12 months post discharge. Results suggest stability of PTSD factor structure across assessment points.

Individual Differences in the Phenomenology of PTSD Over Time
Studying intensive, longitudinal data on PTSD symptoms in individuals allows examination of diversity in the course of traumatic stress responses.Using Ecological Proximal Assessment (a portable, automated, electronic, data collection method), we studied symptoms of PTSD and moods in 60 trauma survivors who were injured hospital patients or family members of injured patients. Psychological phenomena were assessed every 4 hours for a week, beginning 2 to 8 days after injury. Results showed clear differences in symptoms and moods between those who developed PTSD (assessed 2 months post-event) and those who recovered (no PTSD at 2 months). Within the group that developed PTSD, we observed a diverse pattern of emotional responses that appear to reflect three response subtypes: typical Acute Stress Disorder, Numb, and Volatile. We will present data showing evidence of subtypes in individual trauma survivors and data comparing the subtypes on characteristics such as personality disorder symptoms (MCMI Axis II subscales) and PTSD and depression symptoms assessed at three times (2 to 8 days after trauma, 9 to 16 days after trauma, and 2 months after trauma). Analyses of additional variables will be presented to shed light on possible explanations for subtypes and their implications for assessment and treatment.

Papers
PTSD After Mass Shootings

Salons 7 – 9, 3rd Floor

Chair: Laura DiGrande, DRPH, MPH,
Division of Epidemiology, New York City Department of Health and Mental Hygiene, New York, New York, USA

A Prospective Examination of Risk Factors for PTSD Following a Mass Shooting

(Abstract #196512)

Paper Presentation (Disaster, Prev El)

Hattula, Mandy, MA[1]; Orcutt, Holly, PhD[1]; Varkovitzky, Ruth, BS[1]
[1]Northern Illinois University, De Kalb, Illinois, USA

Peritraumatic dissociation is widely considered a risk factor for the development of PTSD; however, the nature of this relationship is unclear. Researchers have proposed that peritraumatic dissociation may be related to experiential avoidance, in that dissociative experiences during a trauma function as a mechanism to avoid unwanted thoughts, emotions, and memories that a person is otherwise unable to regulate. The present study aims to examine the prospective relationship between emotion regulation difficulties, experiential avoidance, peritraumatic dissociation, and PTSD symptoms among survivors of the mass shooting that occurred at Northern Illinois University on February 14, 2008. Emotion regulation difficulties and experiential avoidance were assessed at Time 1 (pre-shooting) among 820 undergraduate females. Peritraumatic dissociation and traumatic stress symptoms were measured in a post-trauma assessment that was launched March 2, 2008. As of March 14, 2008, follow-up assessments were available for 446 participants, with data collection ongoing. Difficulties with emotion regulation and experiential avoidance are hypothesized to predict traumatic stress symptoms related to the shooting, with peritraumatic dissociation serving as a partial mediator of this relationship.

The Mental Health and Attitudes of People With a Personal Connection to the 9/11 Terrorist Attacks

(Abstract #196493)

Paper Presentation (Disaster, Practice)

Jones, Darren, MA[1]
[1]Psychology, University of Toledo, Toledo, Ohio, USA

The study examined the mental health and attitudes of people who had a personal connection to the September 11th, 2001 terrorist attacks. The data was drawn from the Collaborative Psychiatric Epidemiology Surveys (CPES) and was collected between 2001 and 2003. The CPES study is part of the National Comorbidity Survey project and its data is freely available online for research purposes. The study investigated a variety of key mental health indicators, including measures of depression, anxiety, and Posttraumatic

stress symptoms, among those participants that reported either knowing someone that was killed in the 9/11 attack (n = 378), knowing someone that was injured in the 9/11 attack (n = 113), or was an in person witness to the attack or the scene of the attack in the days following the event (n = 77). In addition, the impact of 9/11 on employment, income, patriotism, perceptions of safety, and feelings about the future were examined. Both between and within subject designs were utilized in order to examine the impact of both direct and indirect exposure to terror events. The study includes results, discussion, limitations, implications, and recommendations related to the diagnosis and treatment of those impacted by terror events.

PTSD and Risk Factors in Lower Manhattan Residents 2-3 Years After 9/11

(Abstract #195963)

Paper Presentation (Disaster, Asses Dx)

DiGrande, Laura, DRPH, MPH[1]; Perrin, Megan, MPH[2]; Thorpe, Lorna E., PhD[3]; Wu, David, MS[3]; Farfel, Mark, SCD[3]; Brackbill, Robert, PhD[4]

[1]Division of Epidemiology, New York City Department of Health and Mental Hygiene, New York, New York, USA
[2]Nathan Kline Institute for Psychiatric Research, Orangeburg, New York, USA
[3]New York City Department of Health and Mental Hygiene, New York, New York, USA
[4]ATSDR/NYC Department of Health and Mental Hygiene, New York, New York, USA

Research conducted after 9/11 documented resolution of PTSD in the general NYC population within six months. However, Lower Manhattan residents may have exhibited more persistent sequelae due to their proximity to the WTC epicenter. Between 9/2003 and 11/2004, we administered a CATI questionnaire to 11,037 adults who lived south of Canal Street on 9/11. Questions included demographics, peri- and post- event exposures, and the PTSD-Checklist. Multivariable logistic regression identified risk factors for PTSD. The prevalence of current probable PTSD was 12.6% (95% CI 12.0-13.2) and associated with older age, female gender, Hispanic ethnicity, and low education and income. Residents reporting injury, witnessing horror, and dust cloud exposure were at increased risk for PTSD. Post-disaster risk factors included evacuation and participation in rescue/recovery work. We conclude Lower Manhattan residents were at increased risk for PTSD several years after 9/11. The relationship between SES and PTSD suggests surveillance and interventions should target marginalized populations living in the area. Understanding how the post-disaster environment affects local communities can assist preparedness work to reduce the mental health burden of future disasters.

The Relationship Between Depression and Posttraumatic Stress Disorder Following a Mass Trauma

(Abstract #196360)

Paper Presentation (Disaster; Asses Dx)

Weiner, Elliot, BA[1]; Cukor, Judith, PhD[1]; Wyka, Katarzyna, MA[1]; Difede, Joann, PhD[1]

[1]Cornell University, New York, New York, USA

Purpose: Depression is a common psychiatric reaction to trauma, however, its relationship to posttraumatic stress disorder (PTSD) remains unclear. This study examines the nature of Major Depression (MDD) in comparison to PTSD in disaster workers after a terrorist attack. Methods: 3,523 workers deployed to Ground Zero after 9/11 were diagnosed using the SCID and CAPS and surveyed with self-report measures between June 2002 and December 2007.

Findings: At initial screening, 3.3% met diagnostic criteria for MDD only, 5.0% met criteria for PTSD only, and 3.1% met criteria for both MDD and PTSD. These groups differed significantly with regard to degree of exposure to the trauma, prior trauma history, and history of depression ($p < .05$ for all). MDD and PTSD were significantly more likely to remit by one-year follow-up when presenting independently than comorbidly ($p < .001$), though 18.4% of those who initially presented with only MDD developed PTSD by follow-up. While all three groups reported significant functional impairment, individuals with comorbid MDD and PTSD had greater impairment than those with either disorder alone ($p < .05$ for all).

Conclusions: MDD and PTSD each develop after unique histories and have unique courses, while comorbid MDD and PTSD are a synergistic combination resulting in significantly greater impairment and decreased likelihood of remission.

Assessing Readjustment From OIF/OEF Using the Post-Deployment Readjustment Inventory

(Abstract #195709)

Workshop/Case Presentation (Asses Dx, Mil Emer) **Salon 2, 3rd Floor**

Katz, Lori, PhD[1]; McCarthy, Anna, PhD[2]; Williams, Jenny, MSW[2]; Cojucar, Geta, MS[2]

[1]Mental Health, VA Long Beach Healthcare Systemt, Long Beach, California, USA
[2]Mental Health, VA Long Beach Healthcare System, Long Beach, California, USA

This workshop will address assessment issues regarding readjustment of post-deployed men and women who served in Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF). The results of three studies utilizing the Post-Deployment Readjustment Inventory (PDRI) (Katz, et al, 2007; Katz, et al, in review; Katz, et al, in progress) will be reviewed. The PDRI is a new measure that has strong internal consistency and convergent validity with standardized measures of symptoms. Exposure to certain types of war stressors (e.g., military sexual trauma, being injured, and witnessing death) seems to predict unique patterns of PDRI readjustment scores. With psychotherapy treatment, readjustment scores reflect changes over time. Other variables related to readjustment such as gender differences, resiliency, and risk factors will also be discussed. The audience will learn how to administer and score the PDRI. In addition, we will propose a model that distinguishes between "normal" and "pathological" post-deployment readjustment. Case examples will be presented and treatment recommendations will be proposed.

A New Past-Focused Model for PTSD and Substance Abuse

(Abstract #196182)

Workshop/Case Presentation (Practice, Clin Res) **Salon 1, 3rd Floor**

Najavits, Lisa, PhD[1]; Schmitz, Martha, PhD[2]

[1]VA Boston Healthcare System, Boston, Massachusetts, USA
[2]VA San Francisco, Oakland, California, USA

This workshop presents a new manualized psychotherapy for co-occurring PTSD and substance use disorder (SUD) (Najavits, in press). The new model is designed to offer additional therapeutic work beyond Seeking Safety (Najavits, 2002). Where Seeking Safety teaches coping skills in the present, the new model focuses on processing of past memories and emotions. Seventeen topics are offered, including "explore," "tell your story," "transform pain," "the larger context," and "honor your body." Like Seeking Safety, the new model offers flexible, integrated treatment of PTSD and SUD; and can be used for group or individual treatment; diverse settings and clinicians; and all types of trauma and substances. Similarities and differences with existing evidence-based PTSD and/or SUD treatments will be described. We will also address key issues such as client readiness and engagement, clinician selection, complex cases, research efforts to test the model, and the historical context of past-focused treatment models. The new model can be used alone or in combination with any other treatment.

Concurrent Session 7
Friday, November 14
11:00 a.m. – 12:15 p.m.

DSM-V
Examining the Construct Validity of PTSD and ASD

Factor Structure of PTSD: Implications for *DSM-V*
(Abstract #197962)

DSM-V (Asses Dx, Res Meth) **Grand Ballroom, 4th Floor**

Palmieri, Patrick, PhD[1]
[1]*Summa-Kent State Center for the Treatment and Study of Traumatic Stress, Summa Health System and Kent State University, Akron, Ohio, USA*

The diagnostic criteria for Posttraumatic Stress Disorder (PTSD) have undergone considerable revision since the category was first established in the *DSM-III*. In terms of symptom criteria, the *DSM-IV* describes 3 symptom clusters that are intended to reflect the underlying dimensions of PTSD. These clusters include 5 reexperiencing (e.g., intrusive thoughts; nightmares), 7 avoidance (e.g., avoidance of thoughts, feelings, or conversations; emotional detachment), and 5 hyperarousal (e.g., difficulty sleeping; exaggerated startle response) symptoms related to exposure to one or more traumatic events. The original criteria as well as the revisions, however, were made primarily on rational grounds, leaving questions about the validity of this 3-factor model unanswered.

Confirmatory factor analysis (CFA) is well suited for answering questions about structural validity. Accordingly, many CFA studies have been published in the past 10 years evaluating plausible structural models of PTSD in both military and civilian trauma samples. By far the most consistent finding has been the lack of empirical support for the *DSM-IV* 3-factor model. Among alternative models, two 4-factor models have garnered the most support. The emotional numbing model specifies the same reexperiencing and hyperarousal factors as the *DSM-IV* 3-factor model, but separates the avoidance factor into distinct effortful avoidance and emotional numbing factors. The dysphoria model specifies the same reexperiencing and avoidance factors as the emotional numbing model, but re-casts the emotional numbing symptoms and three of the five hyperarousal symptoms as indicators of a dysphoria, or general distress, factor and views the two remaining symptoms as indicators of a purer hyperarousal factor. Results demonstrate clearly that the *DSM-IV* avoidance symptoms do not reflect a coherent avoidance factor, a fact that any proposed revision to the diagnostic criteria must address.

Research and discussion in the following areas will help guide specific revisions to the PTSD diagnostic criteria: 1) more model invariance testing across samples, instruments, and time; 2) more assessment of construct validity of factors in good fitting models; 3) using additional indicators of putative factors to better cover factor space and yield more stable factor solutions; 4) including indicators of associated factors (e.g., guilt); 5) studying if psychogenic amnesia (which usually has low factor loadings) needs to be assessed differently, or whether it is even an essential feature of PTSD; 6) examining whether linking symptoms to an index trauma versus trauma in general affects model fit; and 7) examining whether different definitions of trauma affect model fit.

PTSD and The Internalizing/Externalizing Model of Comorbidity
(Abstract #197566)

DSM-V (Asses Dx, Bio Med) **Grand Ballroom, 4th Floor**

Miller, Mark, PhD[1]
[1]*Department of Psychiatry, National Center for PTSD, VA Boston Healthcare System, Boston University School of Medicine, Boston, Massachusetts, USA*

This presentation will review evidence for a model of the structure of posttraumatic psychopathology which suggests that patterns of comorbidity and other clinical correlates of PTSD are organized by temperament-based propensities towards internalizing versus externalizing disorders. A theoretical framework for conceptualizing the structure and etiology of patterns of PTSD comorbidity will be presented along with evidence to support the model. Implications for conceptualizing heterogeneity among trauma survivors will be discussed along with recommendations for PTSD biomarker identification and treatment matching.

Acute Stress Disorder in *DSM-V*
(Abstract #198002)

DSM-V (Asses Dx, Prev El) **Grand Ballroom, 4th Floor**

Bryant, Richard, PhD[1]
[1]*University of New South Wales, Sydney, New South Wales, Australia*

Acute stress disorder (ASD) describes initial stress reactions that occur in the initial month after trauma and purportedly predictive of chronic posttraumatic stress disorder (PTSD). There has been much debate about the utility of this disorder. First, it has been criticized because it resembles PTSD in many regards apart from the timeframe. Second, the emphasis placed on dissociation has been challenged by numerous studies. Third, prospective studies of children and adults have shown that the majority of people who develop PTSD do not initially have ASD. The accumulating evidence challenge the utility of the ASD diagnosis and demonstrate that it is not a useful means to identify people shortly after trauma who will develop PTSD. Accordingly, this review will argue that there is insufficient evidence to include ASD in *DSM-V*.

Leave None Behind
(Abstract #193595)

Media Presentation **Salons 4-6, 3rd Floor**

Grenier, Lt. Col Stephane, MSC, CD[1]; ***Bailey, Suzanne, MSW***[2]
[1]*National Defence, Canadian Forces OSI Special Advisor, Ottawa, Ontario, Canada*
[2]*Mental Health Training & Education, Canadian Forces Health Services Group HQ, Ottawa, Ontario, Canada*

The Canadian Forces launched a Speakers Bureau to assist with psycho education within the military community around Canada. The Bureau employs military members and families who have first hand experience with mental health issues and who are trained to deliver educational modules to raise the understanding and acceptance of non physical injuries with an aim at reducing stigma and increasing trust in clinical interventions.

As part of this initiative, two 30 minute long videos were produced as visual support for the Bureau. This video is an educational tool intended for military personnel to raise awareness of mental health and reduce stigma. It introduces the audience to clinical theories surrounding Operational Stress Injuries (OSI) but more importantly, through personal testimony from Canadian Veterans it delivers a strong message regarding the importance of seeking clinical help early and on the critical role that social support plays in the recovery process. Canadian Veterans who served in such places as Bosnia, Croatia, Rwanda and Afghanistan share compelling stories about their struggle after their tours of duty and

the effect on not only themselves but as well on their entire family. This video production completed in March 2005 is now a key component of a nation wide initiative to reduce stigma within the military community.

A City-Wide School-Based Model for Building Resiliency in the Wake of War and Terror

(Abstract #196008)

Symposium/Panel (Child, Commun) **State Ballroom, 4th Floor**

Pat-Horenczyk, Ruth, PhD[1]; Baum, Naomi, PhD[2]; *Brom, Danny, PhD*[2]; Benbenishty, Rami, PhD[3]; Schiff, Miriam, PhD[4]; Astor, Ron, PhD[5]

[1]Hebrew University of Jerusalem, Jerusalem, Israel
[2]Israel Center for the Treatment of Psychotrauma, Jerusalem, Israel
[3]Social Work, Bar Ilan Univeristy, Ramat Gan, Israel
[4]Social Work, Hebrew University, Jerusalem, Israel
[5]University of Southern California, Los Angeles, California, USA

This symposium will present an ecological model for addressing the needs of children and teachers as individuals and the school community as a whole, in coping with the aftermath of exposure to war and terror. The presentations will include discussion of the interventions, and conceptual and methodological issues in the model as applied in Israel.

A Conceptual and Methodological Framework for City-Wide School-Based Monitoring in Communities Exposed to Prolonged and Severe Violence

This presentation will describe the conceptual underpinnings of a city-wide school-based monitoring system. This evidence-driven system is designed to support an ecological public health model for prevention and intervention in communities exposed to prolonged and severe violence such as war, terror, and community crime and violence. The goal of the system is to provide the evidence and processes required to build awareness of the situation, mobilize multiple constituents in the community to address the problems and build resiliency, make informed shared decisions on priorities, resource allocation and appropriate evidence-based interventions, monitor progress over time, assess the effectiveness of interventions, and suggest directions for future change. Monitoring is perceived as a democratic process of eliciting the voices of all members of the school community.

We will present examples that will highlight ethical, methodological and technological challenges and solutions.

Teachers Resilience and Needs in the Wake of War

Our school-based intervention model employs assessment and monitoring of students´ and teachers´ self reports on their psychological and behavioral status and needs. This presentation reports on a teacher survey conducted in parallel to a student assessment process undertaken in the North of Israel, nearly one year after the Second Lebanon War. The aim of the survey was to assess the impact of the war on teachers in terms of Posttraumatic symptoms and difficulties in family and school functioning, their self efficacy in dealing with future challenges, and their perceived needs. We also asked about their perceptions of the effects of the war on their students and their school as a whole.

The sample consisted of 337 Jewish and Arab teachers (a response rate of 30%) who completed structured questionnaires. Our findings indicate that significant group of teachers report on Posttraumatic symptoms and difficulties in functioning a year after the war, and express a range of needs for support for them and for their schools. In the presentation we will compare Arab and Jewish teachers and focus on gaps in services and perceived needs of teachers, both personal and professional.

Do Children Know When They Are Distressed? Employing Students' Self Reports of Emotional Status and Need for Help

Our school based model for building resiliency employs students´ and teachers´ self reports in the processes of assessment and monitoring of psychological and behavioral status, risk and protective factors and needs. The current study examines whether children and adolescents can in fact play an active role in the assessment and monitoring process by directly being asked whether and how much help they need. We examined whether students´ reports on the extent they would like to get help after their exposure to the Second Lebanon war, would be a significant predictor of their distress over and above known risk and protective factors.

The study is based on a representational sampling of all Jewish and Arab (4th-11th grade) students in the North of Israel. The sample included 2,651 Jewish students and 4,028 Arab. Our findings indicate that the students´ report on the total extent of seeking help from all sources was a significant predictor of their distress, over and above background variables, risk factors and protective factors.

A School-Based City-Wide Intervention Model for Building Resilience in the Shadow of War and Terror

This paper presents a school-based intervention model for building resilience among children and adolescents who have been exposed to war and terrorism. The Building Resilience Program is an ecological public health model that addresses the needs of multiple constituents in the school community and combines intervention and prevention on multiple levels. The program was developed by the Israel Center for the Treatment of Psychotrauma in Jerusalem. A major component of the school based intervention is preventive and universal, i.e., to train teachers and other school personnel in understanding resilience, trauma awareness and coping skills. Trained school personnel then educate children and adolescents, through modeling and hands-on activities, in developing the strengths that will buffer traumatic experiences.

A second element of the program focuses on students who have been adversely affected by either direct or indirect exposure to terrorism and war. Students are identified through class administered self reports designed to screen for PTSD and other consequences of exposure to war and terror. Once the diagnosis of PTSD is confirmed, children are offered one of two modules of short-term cognitive-behavioral treatments. This paper presents evidence regarding teachers´ workshops and screening and referral of more than 10000 students.

Current Perspectives on the Role of Cognitive Factors in the Maintenance and Treatment of PTSD

(Abstract #196228)

Symposium/Panel (Clin Res, Asses Dx) **Monroe Ballroom, 6th Floor**

Ehring, Thomas, PhD[1]; Wild, Jennifer, DCLINPSYCH[2]; Heims, Hannah, DCLINPSYCH[2]; Ehlers, Anke, PhD[2]; Stines Doane, Lisa, PhD[3]; Moore, Sally, MS[4]; Echiverri, Aileen, BS[4]; *Zoellner, Lori, PhD*[4]; Feeny, Norah, PhD[3]; Kleim, Birgit, PhD[2]; Grey, Nick, DCLINPSYCH[2]; Hackmann, Ann, DCLINPSYCH[5]

[1]Dept. of Clinical Psychology, University of Amsterdam, Amsterdam, Amsterdam, Netherlands
[2]Dept. of Psychology, Institute of Psychiatry, King's College London, London, United Kingdom
[3]Case Western Reserve University, Cleveland, Ohio, USA
[4]University of Washington, Seattle, Washington, USA
[5]University of Oxford, Oxford, United Kingdom

Cognitive factors are suggested to play a key role in the maintenance of PTSD. The symposium includes new research into the role of cognitive variables in the maintenance of PTSD using experimental and longitudinal designs as well as studies testing whether symptom reduction in PTSD treatment is mediated by cognitive change.

First Responders at the London Bombings of 7 July: Predictors of Recovery From PTSD
(Wild, Heims & Ehlers)

Objectives: This study investigated predictors of recovery from PTSD in a cohort of paramedics who attended the London bombings of 7 July.

Method: First responders who attended the London bombings completed measures of PTSD, depression, emotion regulation, use of social support, alcohol and drug use, cognitive and behavioural responses to intrusive memories, trauma cognitions, trauma history and trauma exposure within one month of exposure to the bombings. They were re-assessed six months later on measures of PTSD, trauma exposure and use of social support. The Structured Clinical Interview for *DSM-IV* Axis I Disorders (SCID) was administered to confirm a diagnosis of PTSD.

Results: Twenty six per cent of paramedics met criteria for PTSD in the aftermath of the London bombings. Six months later, the rate had dropped to 4%. Emotion regulation and adaptive responses to intrusive memories predicted recovery.

Conclusions: The London bombings led to high rates of initial PTSD that resolved significantly within six months. Those who continued to have PTSD demonstrated problems regulating negative emotions in the aftermath of the bombings, as well as dissociating in response to intrusive memories. The results have implications for prevention and intervention planning in the emergency services.

Characteristics of Explicit and Implicit Trauma Memory in PTSD
(Ehring & Ehlers)

Two hypotheses derived from cognitive models of PTSD were tested: (1) the idea that the explicit trauma memory is fragmented and disorganized in PTSD (e.g., van der Kolk & Fisler, 1995) and (2) the hypothesis that PTSD sufferers show a heightened perceptual priming for trauma-related stimuli (Ehlers & Clark, 2000).

We conducted a cross-sectional (N = 101) and a prospective study (N = 147) with injured accident survivors. The degree of trauma memory disorganisation was coded from narratives of the trauma and a non-traumatic event (inter-rater reliabilities: .80 - .95). In addition, a word-stem completion and a picture identification task were used to investigate perceptual priming.

Results from earlier studies showing disorganisation of trauma narratives in PTSD were replicated. However, in contrast to the fragmentation hypothesis, this was not specific for the trauma narrative. The results underline the importance of a control condition when investigating trauma memory characteristics and suggest a modification of the fragmentation hypothesis. Results of the implicit memory tests were in line with the idea that individuals with PTSD showed a heightened perceptual priming for trauma-related stimuli.

Implications for cognitive theories of PTSD and future research will be discussed.

Trauma-Related Cognitions in Critical Sessions: Does Cognitive Change Precipitate Symptom Reduction?
(Stines Doanes, Moore, Echiverri, Zoellner & Feeny)

Evidence suggests that a large proportion of overall symptom reduction in CBT often occurs as a sudden gain (SG), or a large, rapid decrease in symptoms from one session to the next (e.g., Tang & DeRubeis, 1999; Hardy et al., 2005; Stines et al., 2008). Thus, the session prior to the gain may be critical to stimulating these abrupt reductions in symptoms. However, little research to date has examined factors that may precipitate these sudden improvements, and changes in trauma-related cognitions may play a role. The purpose of this study was to explore the relationship between cognitive change and SG in prolonged exposure therapy (PE) for PTSD. Data for the current study were collected as part of an ongoing RCT comparing PE and sertraline; only data from those who received PE were evaluated for this study (n = 110). SG were computed following the methods suggested by Tang & DeRubeis (1999), and reliable cognitive change was computed using the test-retest reliability coefficient reported on the Posttraumatic Cognitions Inventory (Foa, Ehlers, Clark, tolin, & Orsilo, 1999). Preliminary results suggest that 61% of the sample experienced a SG, with 44% occurring prior to session 5. Cognitive change in relation to SG could have significant implications for course of treatment as well as potential modes for treatment augmentation among those who do not respond to PE.

Cognitive Change Mediates Symptom Reduction in Cognitive Therapy for PTSD
(Kleim, Grey, Hackmann, Wild & Ehlers)

Objectives: Cognitive Therapy for PTSD (CT, Ehlers & Clark, 2000) has been shown to be effective, but there is yet little empirical evidence on the hypothesized mechanisms of change. We tested the hypothesis that change in cognitive appraisals characteristic for PTSD mediate symptom reduction with treatment, and that appraisal change precedes symptom change.

Methods: We analysed weekly cognitive and symptom measures from CT sessions.

Results: Preliminary analyses suggested that change in cognitive appraisals from initial assessment to mid-treatment mediate symptom reduction with CT by the end of treatment.

Conclusion: Symptom reduction in cognitive PTSD therapy can be explained by cognitive change during therapy.

Early Diagnosis and Intervention in Mass Casualty Events

(Abstract #196326)

Symposium/Panel (Prev EI, Asses Dx) **Adams Ballroom, 6th Floor**

Kutz, Ilan, MD[1]; Dekel, Rachel, PhD[2]; Schreiber, Shaul, MD[3]; Resnick, Victor, MD[1]; Dolberg, Ornah T., MD[4]; Barkai, Gabriel, MD[4]; Leor, Agnes, MD[4]; Rapoport, Elena, MD[4]; Bloch, Miki, MD[4]
[1]Meir Hospital, Tel-Aviv, Israel
[2]Bar Ilan University, Ramat-Gan, Israel
[3]Sourasky medical center, Tel Aviv, Israel
[4]Psychiatry, Tel Aviv Sourasky Medical Center & Tel Aviv University Sackler Faculty of Medicine, Tel-Aviv, Israel

Since September 2000, Israeli and Palestinian societies suffered great losses. on the Israeli side, civilians of all ages, and ethnic groups, have been exposed to various types of terrorist attacks. This symposium examines issues of diagnosis and interventions in the immediate aftermath of these mass casualties events.

Acute Stress Reaction (ASR): Methods of Assessment and Prediction of Acute Stress Disorder
Purpose: To develop an assessment tool for measuring the intensity of acute stress reaction symptoms in mass causality events and to examine it's ability to predict emotional reactions 4-6 weeks later.

Method: Two ways of measuring the intensity of ASR were compared: verbal and numerical ASR-Rating Scale (ASR-RS), comprised of six clusters of symptoms, based on the literature and accumulated experience of several ER clinicians and the ASR Visual Analogue Scale (ASR-VAS) which include both the general level of distress of the patient, and the Clinical Global Impression (CGI) of ASR, as perceived by the examiner.

Findings: The ASR-VAS was found to be superior to the ASR-Rating Scale because it is simple to use, easy to clinically interpret, and provides clear guidelines for follow-up decisions. The level of ASR-VAS predicted the level of emotional reactions 4-6 weeks later in various types of traumatic events.

Conclusions: The clinician´s use for rating distress by the ASR-VAS is a novel use of the VAS method. Assessment of ASR can be taught to clinicians using a training kit, that includes: An overview presentation of Acute Stress Syndromes; The ASR-RS (for practice guidelines); The ASR-VAS; Training movies with various interviews of simulated ASRs.

The Effect of a Single Session of EMDR on Intrusive Distress in Acute Stress Syndromes
Purpose: To examine the efficacy of a single session of a modified abridged EMDR protocol in reducing Acute Stress Syndromes (ASS) following accidents and terrorist bombing attacks.

Methods: Treatment was provided, in a general hospital inpatient and out-patient setting to 86 patients with ASS.

Findings: Fifty percent reported immediate fading of their intrusive symptoms and general alleviation of their distress, 27% described partial alleviation of their symptoms, while 23% reported no improvement. Four week and six month follow-up, in the terror victims group only, showed that the immediate responders remained symptom free, while half of the non-responders, who also received subsequent additional interventions modalities, were still symptomatic.

Conclusions: The difference in response may be attributed, in part, to the fact that immediate responders tended to have an uncomplicated ASS with fewer risk factors for PTSD, while the non-responders had higher exposure to former traumas and endorsed more risk factors for PTSD. These results support other anecdotal reports on the rapid effects of brief EMDR intervention in uncomplicated cases and offer a psycho-physiological hypothesis for immediate response. While additional controlled studies are essential, this immediate symptomatic relief may be a potential addition for focused interventions in acute trauma victims.

Intervention for Memory Structuring and Meaning Acquisition With Survivors of Terror
Purpose: To assess the impact of a primary intervention for memory structuring and meaning acquisition in the emergency department with survivors of terror on their medium term mental health outcome.

Method: Injured survivors of terror attacks, aged 16-72 were given the intervention at the ER. Follow up assessment 3-9 months and 24 months post injury were conducted.

Findings: Out of 213 injured survivors evacuated to the ED, 129 were retrieved 3-9 months after the incident, and 53 were available for assessment 2 years later. Being hospitalized and treated were the only predictors for PTSD with no effect for the current treatment vs. other supportive intervention.

Conclusion: This treatment is as good as the non-specific supportive treatment performed routinely in the ED.

When Post-Trauma is Also a Pre-Trauma: Working with Mental Health Teams Under Ongoing Rocket Attacks
Purpose: Improving the skills of an outpatient mental health team (MHT) in Sderot, a town that has been bombarded by rocket attacks for the past seven years. This MHT were charged with providing a comprehensive mental health outpatient services while manning the acute stress intervention site and responding to daily mass casualty events.

Method: A psychiatrist experienced in trauma intervention sent to improve trauma intervention skills to the MHT.

Findings: The posttraumatic symptoms of the sensitized residents were compounded by 'pre-traumatic' symptoms of hyper-vigilance, helplessness, and demoralization in anticipation of the next attacks. There was no 'safe place' for psychological intervention.The MHT members were also suffering from emotional exhaustion and demoralization. Gradually, both supervisor and MHT members had to redefine concepts like safety, stress and survival. The process involved a gradual shift from explicit teaching and supervision to implicit group and individual support, employing principles of individual, family and community interventions.

Conclusions: The attempt of supervisor and team to enter an enduring alliance afforded a growth experience with some restructuring of outer reality (like intervention protocols) while expanding professional insight (recognition of limitations, developing group cohesion).

Improving Disaster Mental Health Care Through Evaluation: Program Outcomes and Treatment Referrals

(Abstract #196392)

Symposium/Panel (Disaster; Clin Res) **Salons 7-9, 3rd Floor**

Norris, Fran, PhD[1]; Rosen, Craig, PhD[2]; Hamblen, Jessica, PhD[3]; Matthieu, Monica, PhD[4]; Pietruszkiewicz, Siobhan, LSCW[5]; Gibson, Laura, PhD[6]; Naturale, April, MSW[7]; Louis, Claudine, PhD[8]
[1]Dartmouth College, White River Junction, Vermont, USA
[2]Stanford University, Menlo Park, California, USA
[3]VA National Center for PTSD, White River Junction, Vermont, USA
4School of Social Work, Washington University, St. Louis, Missouri, USA
[5]School of Social Work, Louisiana State University, Baton Rouge, Louisiana, USA
[6]University of Vermont, Burlington, Vermont, USA
[7]Silver School of Social Work, New York University, Montclair, New Jersey, USA
[8]Dartmouth Medical School, White River Junction, Vermont, USA

The high prevalence of PTSD after disasters has sparked tremendous interest in improving the quality of mental health care for disaster victims. Presenters describe program outcomes and examine linkages between crisis counseling programs that aim to provide extensive services to the general population and treatment programs that aim to provide intensive programs to distressed individuals.

Service Characteristics and Outcomes: Lessons From a Cross-Site Evaluation of Crisis Counseling After Hurricanes Katrina, Rita and Wilma
The 2005 hurricane season was the worst on record in the USA, resulting in disaster declarations and the implementation of federally-funded crisis counseling programs in five states. After Katrina, the CCP implemented a standardized data collection system for cross-site evaluation. Data from 2,850 participant surveys, 805 provider surveys, and 132,733 encounter logs were aggregated to the county level (N = 50) and used to test hypotheses regarding factors that influence program performance. Program performance was measured by the Counseling Outcomes and Experiences Scale (COES), a 10-item (100-point) scale that assesses the extent to which the counselor (a) created an encounter characterized by respect, cultural sensitivity, and sense of privacy and (b) achieved realistic immediate outcomes as perceived by the participant. There was striking variability across the 50 counties. County-level outcomes improved as service intensity, service intimacy, and frequency of psychological referrals increased, and as provider job stress decreased. The percent of providers with advanced degrees was indirectly related to outcomes by increasing service intensity and referral frequency. The results yielded recommendations for achieving excellence in disaster mental health programs.

Factors Predicting Referrals to Other Crisis Counseling, Disaster Relief, and Psychological Services After Hurricane Katrina
Nationwide data from 703,000 individual counseling encounter logs completed by workers in 19 crisis counseling programs funded in the aftermath of Hurricane Katrina were analyzed to draw conclusions about factors that influence crisis counselors´ decisions to make referrals to other crisis counseling services, disaster relief, and psychological services. Between Months 3 and 18 postdisaster, 159,500 persons (22.7%) were referred to other crisis counseling, 410,500 (58.4%) to disaster relief, and 46,500 (6.6%) to psychological services. Referrals to disaster relief were stable, but referrals to other crisis counseling and psychological services declined sharply over time. Encounters in urban settings were far more likely to yield referrals of all types, especially to psychological services. Disaster experiences predicted referrals of all types, but psychological referrals were related more strongly to participants´ past mental health problems than to experiences in Katrina. Adults, especially young and middle-aged adults, were much more likely to receive psychological referrals than were

children. A participant survey suggested that the prevalence of need for psychological services far exceeded the prevalence of referrals to those services.

Evaluation of Cognitive Behavioral Therapy for Post-Disaster Distress (CBT-PD) for Hurricane Katrina Survivors
Hurricane Katrina displaced hundreds of thousands of residents of New Orleans, many of whom settled in Baton Rouge, Louisiana. The Baton Rouge Area Foundation sponsored a mental health initiative, the cornerstone of which was InCourage, a free 10-session program of CBT-PD that local (predominantly masters-level) clinicians were trained to provide. During 2007, 128 persons (80% female, 57% African American) enrolled in InCourage. to date 80 persons have completed the program, which is still active. Participants were assessed five times (referral, pretreatment, intermediate treatment, posttreatment, and 4-month follow-up). Consistent with hypotheses, participants showed little change between referral and pretreatment or between posttreatment and follow-up, but large change between pretreatment and intermediate treatment (ES = 1.2) and again between intermediate treatment and posttreatment (ES = 1.0). Effect sizes were comparable for White and African American participants and for persons with very high and moderately high symptomatology at enrollment. Although InCourage was effective for completers, the number of participants was less than anticipated. Issues that may have influenced enrollment and retention are discussed.

EMDR HAP Training in Pakistan in the Aftermath of the 2005 Earthquake and the 'War on Terror'

(Abstract #196217)

Paper Presentation (Disaster; Media Ed) **Salons 7-9, 3rd Floor**

Farrell, Derek, PhD[1]; Tareen, Saleem, MBBS[2]; Keenan, Paul, MSC[3]
[1]College of Medicine, University of Birmingham, Edgbaston, Birmingham, United Kingdom
[2]General Adult Psychiatry, Belfast Health & Social Care, Belfast, United Kingdom
[3]Faculty of Health, Edge Hill University, Liverpool, United Kingdom

On Saturday 8th October 2005, a devastating earthquake measuring 7.6 on the Richter scale struck northern Pakistan. The magnitude of the earthquake wiped out entire villages and communities, destroyed 400,000 houses and created over 73,000 fatalities and 135,000 people injured.

EMDR UK & Ireland, EMDR Europe, the British/ Pakistani Psychiatric Association & the University of Birmingham supported an eighteen month Humanitarian Assistance Programme to help train forty-nine mental health workers, mainly psychiatrists and psychologists from the earthquake affected areas, in the theory and practice of EMDR in the management of psychological trauma. This programme was one of the first University based HAP trainings in EMDR ever to be undertaken.

This paper will provide an insight into the development and progression of the trainings in light of the ongoing political problems in Pakistan both in terms of post earthquake reconstruction and the continued threat of terrorist attacks throughout Pakistan. It will also consider cultural perspectives of trauma and how this related to both EMDR and the conceptual framework of PTSD. The paper will also highlight some of the psychometric data acquired from survivors from the earthquake areas and demonstrate the ways in which EMDR is being utilised as a psychological treatment intervention in Northern Pakistan.

Papers
Refugee Mental Health

Crystal Room, 3rd Floor

Chair: Kenneth Carswell, DCLINPSYCH, MPHIL, BA,
The Traumatic Stress Clinic, London, United Kingdom

Trauma, Mental Health, and Anger in Timor Leste

(Abstract #196374)

Paper Presentation (Civil Ref, Cul Div)

Steel, Zachary, MPSYCHOL(CLINICAL)[1]
[1]Centre for Population Mental Health Research, School of Psychiatry, University NSW, Liverpool, New South Wales, Australia

There has been a strong tendency for epidemiologic studies in post-conflict developing countries to focus on PTSD and depression. Clinical observations suggest that exposure to persecution may generate a wider array of outcomes amongst survivors including persisting anger. This paper reports on the findings of a two-phase small area total population survey of 1,544 adults in an urban and rural area of Timor Leste between February and November 2004. The study assessed the prevalence of PTSD, depression, psychosis, and fiu kotu, a severe, explosive form of anger identified in that culture. The prevalence of PTSD and depression was low despite extensive population wide exposure to trauma. However, 38% of respondents reported episodes of fiu kotu with the risk for this condition increasing with heightened exposure to trauma. These findings provide a challenge for clinical researchers to examine a broader range of outcomes in culturally diverse trauma affected populations.

Terror and its Aftermath: Impact of Persecution and Refugee Camp Experiences on Arab Immigrant Women

(Abstract #196543)

Paper Presentation (Cul Div, Civil Ref)

Norris, Anne, PhD, APRN BC, FAAN[1]; Aroian, Karen, PhD, RN, FAAN[2]
[1]William F. Connell School of Nursing, Boston College, Chestnut Hill, Massachusetts, USA
[2]College of Nursing, University of Central Florida, Orlando, Florida, USA

It has been argued that persecution significantly damages the self, particularly in relation to others, increasing risk of PTSD and depression symptoms, but other research highlights multiple trauma's damaging effects. Many Arab immigrant women have experienced persecution or a multiply traumatizing refugee camp. This study investigated effects of pre-migration persecution and refugee camp experiences on post-migration functioning in Arab Muslim immigrant women (n=635) who completed Arabic language versions of the POMS, CES-D, PDS, social support and stress measures, and measures of immigration and demographic characteristics during interviews in their homes. Few women (6%) reported only refugee camp experience. More reported persecution only (23%) or both persecution and refugee camp (27%). Many reported neither (44%). No interaction effect was observed: Women who only experienced persecution or a refugee camp were not significantly less distressed or symptomatic than those who experienced both ($p > .50$). Women not reporting these experiences were least symptomatic of PTSD ($p < .01$). No group differences were found for social support ($p=.27$) arguing against damage to self in relation to others being uniquely related to persecution. Findings underscore negative effects of persecution and repetitive trauma, and highlight need for intervention with study population.

Culture, Trauma, and Psychiatric Impairment Amongst Vietnamese Living in Vietnam and Australia

(Abstract #196320)

Paper Presentation (Civil Ref, Cul Div)

Steel, Zachary, MPSYCHOL(CLINICAL)[1]
[1]Centre for Population Mental Health Research, School of Psychiatry, University New South Wales, Liverpoool, New South Wales, Australia

Uncertainty persists about the long-term mental health of post-conflict populations and resettled refugees. The present paper assesses the contributions of trauma to mental disorder amongst Vietnamese refugees resettled in Australia and resident in the Mekong Delta region of Vietnam. The study involved multi-stage probabilistic samples of Vietnamese refugees resettled in Australia for 11 years (n = 1,161) and from Can Tho City and Hou Gian Province in Vietnam (n=3039). Both surveys applied the CIDI and an indigenously-derived measure of mental disorder. In the Australian sample Latent Class Analysis identified three classes of respondents on the basis of trauma exposure: (1) war affected ex-combatants; (2) Vietnamese exposed to trauma during refugee flight; and (3) a no trauma group. In the Mekong Delta group two classes emerged: (1) war affected ex-combatants (2) and a no trauma group. Despite a low prevalence of mental disorder amongst Vietnamese in both surveys the trauma affected classes remained at high risk of mental disorder. of notable interest was evidence to suggest that the manifestation of mental disorder amongst both trauma affected and non-trauma affected respondents is affected by exposure to westernization.

The Relationship Between Post-Migration Problems and Refugee Mental Health

(Abstract #196304)

Paper Presentation (Practice, Sos Ethic)

Carswell, Kenneth, DCLINPSYCH, MPHIL, BA[1]; Barker, Chris, PhD, MA, MSC, BA[2]; Blackburn, Pennie, DCLINPSYCH, MA[3]
[1]The Traumatic Stress Clinic, London, United Kingdom
[2]Sub-Department of Clinical Health Psychology, University College London, London, United Kingdom
[3]Mangere Refugee Reception Centre, Auckland, New Zealand

There is growing evidence of the impact of the post-migration environment on the mental health of refugees and asylum seekers. to date, there has been little research conducted in the UK. Participants (n = 47) recruited from clinical settings completed self-report measures assessing post-migration problems, psychopathology and social support. Bivariate associations were identified between psychopathology and number of traumas, adaptation difficulties, a loss of culture and support and social support. In multivariate analyses post-migration problems were significantly associated with psychopathology, but there were no significant associations between psychopathology and number of traumas or social support. The findings are discussed with reference to clinical services and UK asylum policy. Changes to UK asylum policy have attempted to assist the integration of individuals by reducing the amount of time taken to process applications, whilst also making the process of adaptation more difficult through practices including the provision of temporary leave to remain, dispersal of asylum seekers and restricted rights to work and education.

Papers
First Responders

Wabash Room, 3rd Floor

Chair: Neil Greenberg, MD,
King's College London, London, United Kingdom

Atypical Work Hours and PTSD Among Police Officers

(Abstract #196135)

Paper Presentation (Mil Emer, Sos Ethic)

Violanti, John, PhD[1]; Hartley, Tara, MS[2]; Mnatsakanova, Anna, MS[2]; Andrew, Michael, PhD[3]; Burchfiel, Cecil, PhD[4]
[1]Social & Preventive Medicine, University at Buffalo, Buffalo, New York, USA
[2]Health Effects Laboratory Division, NIOSH, Centers for Disease Control and Prevention, Morgantown, West Virginia, USA
[3]Health Effects Laboaratory Division, NIOSH, Morgantown, West Virginia, USA
[4]Biostatistics and Epidemiology Branch,, National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention, Morgantown, West Virginia, USA

The impact of circadian disruption (shift work) on PTSD symptomatology has not yet been adequately examined. This cross-sectional study of 111 police officers examined associations between shift work and PTSD that could be influenced by irregular sleep hours and police rank. Shift work data were obtained from daily payroll records between 1994 -2000, categorized as day, afternoon or midnight, based on the highest percent of hours worked on each of these shifts. PTSD symptoms were measured with the Impact of Event Scale (IES). Sleep duration was dichotomized (<6 vs. 6 hours/day) and police rank as patrol officer vs. other. IES scores were compared across shift types using ANOVA and ANCOVA. Officers working midnight shift had higher IES scores than officers working day or afternoon shifts (15.77 vs. 13.98 and 15.09, respectively). Adjustment for age and gender did not alter the results. Stratification by sleep duration yielded the highest IES score for midnight shift workers with insufficient sleep (<6 hours/night) compared with dayshift workers (22.00 vs. 13.07, p=0.59). Among patrol officers, midnight shift workers had the highest IES score compared to dayshift workers (16.05 vs. 7.72, p=0.098). These results suggest cross-sectional associations between shift work and PTSD symptoms among patrol officers.

The Psychological Impact of the 7th July London Bombings Upon London Ambulance Service Personnel

(Abstract #195909)

Paper Presentation (Mil Emer, Disaster)

Greenberg, Neil, MD[1]; Misra, Monika, MD[2]
[1]King's College London, London, United Kingdom
[2]Occupational Health, King's Collegel London, London, United Kingdom

Aim: To assess the psychological impact of the London bombings of July 7th 2005 on London Ambulance Service (LAS) personnel. Method: Cross sectional questionnaire survey two months after the bombings of all 525 London Ambulance Service personnel involved in the bombings, and a control group. Probable PTSD was assessed using the Trauma Screening Questionnaire, and substantial, psychological, distress,using an identical tool used to assess the emotional impact of the bombings on the population of London.

Results: 341 (32%) responded. 4.3% reported probable PTSD & 13% reported substantial distress. Probable PTSD was more common in those involved in the bombings or who worked at the disaster scene. The majority were aware of the post incident support available and how to access this, moreso if personnel were involved in the bombings.

Conclusions: Despite dealing with the aftermath of the bombings LAS did not reported higher levels of probable PTSD and

psychological distress than the rest of the London population. However those more proximal to the incident were more likely to have been affected in spite of being aware of various staff support measures put in place.

9/11 Responders and High Rates of Posttraumatic Stress Disorder

(Abstract #196487)

Paper Presentation (Asses Dx, Clin Res)

Barrett, Minna, PhD[1]; Demaria, Thomas, PhD, Vice President Behavioral Health[2]
[1]Psychology, State University of New York at Old Westbury, Oceanside, New York, USA
[2]Behavioral Health, South Nassau Communities Hospital, Oceanside, New York, USA

This paper reports results on rates of emotional distress in 310 9/11 First Responders who participated in rescue and recovery during the attacks/aftermath and who sought health monitoring/mental health treatment services for respite, post-trauma symptoms or family dysfunction. Employing a federally approved assessment protocol, mental health staff in a federally sponsored program dedicated to 9/11 responders, provided services to more than 4000 rescue, recovery and cleanup workers and about 300 of their spouses and children. The protocols include assessment of: direct exposure (NIH 9/11 Impact Scale); health, physical and emotional (SF 36); post trauma impact (Penn Inventory of Posttraumatic Stress); depression (BDI) and five other measures. Rates of PTSD were 300% higher than those reported in a similar study of Oklahoma City Firefighters suggesting that professional Firefighters (FDNY), with rates of 49% PTSD, may not necessarily be inoculated to the psychological impacts of this work as was posited by North, et. al. (2002). Findings of Bacharach and Zelko (2004), Levin et.al. (2006) and Raskin (2005) with regard to psychological and health impacts of 9/11 on Responders are shared along with importance of cultural sensitivity during assessment and implications for intervention during and following terrorist attacks.

Manhattan Clinicians' Resilience and Professional Satisfaction in the Aftermath of the 9/11 Disaster

(Abstract #196491)

Paper Presentation (Practice, Disaster)

Tosone, Carol, PhD[1]
[1]Silver School of Social Work, New York University, New York, New York, USA

Purpose: This paper uses cluster analysis to examine relationships among six psychological variables in a sample exploring the long-term impact of 9/11 on Manhattan clinicians.

Methods: A total of 481 clinicians from the NASW Manhattan Chapter (38% response rate) replied by mail to the Post 9/11 Quality of Professional Practice Survey.

Findings: A three cluster solution was chosen for substantive interest. Of 481 respondents, 294 are in a cluster showing the highest resiliency and compassion satisfaction, and the lowest compassion fatigue, posttraumatic stress, and ambivalent and avoidant attachment. The other two clusters, one with 89 respondents and one with 98 showed more unusual patterns. The first were relatively high on resiliency and compassion satisfaction but showed the highest levels of compassion fatigue, posttraumatic stress, and ambivalent and avoidant attachment. The final cluster had the lowest resiliency and compassion satisfaction, and moderate on all other measures.

Conclusion: Although one might expect respondents high on compassion satisfaction and resiliency to be correspondingly low on compassion fatigue, posttraumatic stress, and ambivalent and avoidant attachment, findings indicated somewhat paradoxical relationships among these variables. Clinicians could be professionally satisfied yet experience professional fatigue and PTSD symptoms.

Supported Employment Versus Standard Vocational Rehabilitation for Veterans With PTSD

(Abstract #196205)

Workshop/Case Presentation (Clin Res, Practice) **Salon 1, 3rd Floor**

Davis, Lori, MD[1]; Drebing, Charles, PhD[2]; Toscano, Rich, MA[3]; Riley, Allen, MS[1]; *Drake, Robert, MD*[4]; Newell, Jason, PhD[1]
[1]Research (151), VA Medical Center, Tuscaloosa, Alabama, USA
[2]Mental Health, Bedford VA Medical Center, Bedford, Massachusetts, USA
[3]Institute on Human Development and Disability, University of Georgia, Decatur, Georgia, USA
[4]Harvard University, Hanover, New Hampshire, USA

Posttraumatic stress disorder (PTSD) often causes chronic occupational dysfunction and may lead to unemployment or disability. This workshop will present a description of Individual Placement Services (IPS), an evidenced based supported employment (SE) method of vocational rehabilitation, and make a comparison with standard vocational rehabilitation programs (VRP). While IPS SE has been proven more effective than standard VRP in the serious mentally ill (SMI; i.e. psychotic disorders), it has not been adequately studied in PTSD populations. Preliminary data and case examples from an ongoing randomized trial of IPS SE versus standard VRP in veterans with PTSD will be presented and discussed. In addition, case examples and data from a multi-site "pathways-to-care" study of 200 veterans with mental health (33% with PTSD) and vocational problems will be presented. This study includes a random assignment trial of motivational interviewing and provides evidence that the single-session intervention resulted in a 50% increase in both entry and retention rates in vocational rehabilitation services. Challenges of occupational recovery and symptomatic management of PTSD during vocational rehabilitation will be discussed. The essential elements of IPS SE treatment fidelity will be clearly delineated. Barriers to occupational recovery in patients with PTSD will also be discussed.

Conducting Ethical and Responsible Trauma-Focused Research With Special Populations

(Abstract #195959)

Workshop/Case Presentation (Res Meth, Sos Ethic) **Salon 2, 3rd Floor**

Nelson Goff, Briana, PhD[1]; Schwerdtfeger, Kami, PhD[2]
[1]Kansas State University, Manhattan, Kansas, USA
[2]Oklahoma State University, Stillwater, Oklahoma, USA

Recent emphasis on the ethical conduct of researchers has resulted in a growing body of literature exploring the impact of trauma-focused research on participants. This workshop will focus on applying ethical principles of research (autonomy, beneficence, nonmaleficence, and justice) in trauma-focused research protocols. to illustrate these ethical principles, the presenters´ experience conducting research with special populations of trauma survivors, specifically pregnant females and couples in which one or both partners have a trauma history will be described. These are two groups of participants that are unique for trauma research, primarily because of the Institutional Review Board and ethical considerations for research with these populations, as well as the broader systemic impact trauma may have. The presenters will provide examples of direct experience with conducting trauma-focused research with special populations, barriers and issues that need to be addressed in the research, and benefits from their research for participants, the researchers, and the broader field of traumatic stress. The workshop will include a focus on a couple and family systems perspective, a lifespan perspective, and the role of resilience in the research procedures and results. Best

practices for conducting ethical trauma-focused research will be provided. As well, recommendations for future research will be outlined in an effort to further extend the ethical understanding of the benefits and costs of trauma-focused research.

The Challenges of Conducting and Analyzing Small to Moderate Sized Longitudinal Studies

(Abstract #196236)

Workshop/Case Presentation (Res Meth, Asses Dx) **Salon 3, 3rd Floor**

Sunday, Suzanne, PhD[1]; Labruna, Victor, PhD[1]; Kaplan, Sandra, MD[1]; Kline, Myriam, PhD[1]
[1]Psychiatry, North Shore University Hospital, Manhasset, New York, USA

Conducting longitudinal research is a challenging endeavor and provides unique methodological and statistical difficulties. Follow-ups, particularly those with intervals of 10 years or more, often have retention rates of less than 50% and longitudinal studies of trauma survivors often have very high rates of loss to follow-up. Participant attrition presents unique obstacles to the conduct and analysis of such studies. It is the purpose of this workshop to discuss the difficulties of conducting and analyzing a 10-15 year follow-up of young adults who were documented as physically abused during adolescence. In the original study, 99 physically abused and 99 comparison middle-class adolescents we re enrolled. Follow-up participants were 67 in the physical abuse group and 76 in the comparison group. Issues of subject retention and comparisons between follow-up participants and non-participants will be presented. Qualitative and quantitative analyses of data, approaches to handling missing data, statistical and graphic analyses of regressions and interactions, and the development of models of risk factors and outcomes will be discussed and the results and interpretations of these analyses will be compared and contrasted. Workshop participants will be encouraged to share their own longitudinal research issues and questions during the workshop.

Concurrent Session 8
Friday, November 14
2:00 p.m. – 3:15 p.m.

DSM-V
Should There be a Complex Trauma Diagnosis in *DSM-V?*

Developmental Trauma Disorder: Towards a Rational Diagnosis of the Sequelae of Chronic Childhood Abuse and Neglect

(Abstract #198507)

DSM-V (Asses Dx, Res Meth) **Grand Ballroom, 4th Floor**

van der Kolk, Bessel, PhD[1]; Ford, Julian, PhD[2]; Stolbach, Bradley, PhD[3]; Spinazzola, Joseph, PhD[4]; D'Andrea, Wendy[5]
[1]Boston University School of Medicine, Brookline, Massachusetts, USA
[2]University of Connecticut Health Center, Farmington, Connecticut, USA
[3]La Rabida Children's Hospital, Chicago, Illinois, USA
[4]Boston University, Brookline, Massachusetts, USA
[5]University of Michigan, Ann Arbor, Michigan, USA

Purpose: Each year over 3,000,000 children are reported to the authorities for abuse and/or neglect in the US. Research has well documented that adverse childhood experiences have a powerful relation to adult health a half-century later and expressed as increased depression, suicide attempts, alcoholism, drug abuse, sexual promiscuity, domestic violence, obesity, and a variety of physical illnesses. Childhood trauma is probably our nation´s single most important public health challenge.

Method: While isolated traumatic incidents tend to produce discrete conditioned behavioral and biological responses to reminders of the trauma, as captured in the PTSD diagnosis, chronic maltreatment has well-documented and pervasive effects on the development of mind and brain. This workshop will present convergent data from 10 different data bases comprising over 100,000 children that document consistent problems with affect regulation, dissociation, cognition, and interpersonal relationships that are not captured in the PTSD diagnosis. Some of these problems are currently captured by a variety of different *DSM* "co-morbid" diagnoses.

Conclusion: We will conclude with provisional diagnostic criteria for Developmental Trauma Disorder as formulated by the NCTSN *DSM V* Taskforce.

What is Complex About Complex PTSD and Does it Matter for Treatment?

(Abstract #197963)

DSM-V (Asses Dx, Clin Res) **Grand Ballroom, 4th Floor**

Cloitre, Marylene, PhD[1]
[1]Institute for Trauma and Resilience, New York University Child Study Center, Cathy and Stephen Graham Professor of Child and Adolescent Psychiatry, New York, New York, USA

Complex PTSD has been defined as arising from exposure to prolonged and multiple traumatic stressors, typically of an interpersonal nature and often in childhood, that inflict harm to the physical or psychic integrity of the person (e.g., childhood abuse, neglect, domestic violence, being taken hostage, witness to or target of genocide). Such experiences can result in self-regulatory disturbances which include not only PTSD symptoms but also self-destructive and impulsive behaviors, substance abuse, chronically impaired relationships with others, dissociation, and somatic and identity disturbances. While it has been argued that these problems can be readily captured through the designation of one or more co-morbid psychiatric disorders, many of the symptoms

do not reach threshold for such a designation and thus fall "under the radar" for formal identification and consequently, effective treatment. This presentation will offer data indicating that (1) increased type of traumatic exposures, particularly in childhood is associated with increasingly complex symptom profiles and (2) the accumulation of various self-regulatory symptom clusters as defined above (and that do not meet criteria for a psychiatric disorder) significantly contribute to functional impairment. Treatment implications will be discussed.

Dissociation and the Complex Trauma Reactions

(Abstract #198501)

DSM-V (Asses Dx, Practice) **Grand Ballroom, 4th Floor**

Vermetten, Eric, MD, PhD[1]; Lanius, Ruth, MD, PhD[2]
[1]Central Military Hospital Q3, Military Mental Health – Research Center, Utrecht, Netherlands
[2]University of Western Ontario, London, Ontario, Canada

Traumatic dissociation has a long tradition that has seen a come and go in psychiatry. The psychiatric approach to the dissociative disorders for long time failed to acknowledge any relationship to psychological trauma. Before *DSM-III* dissociation was grouped with the old remnant of hysteria, conversion disorder, and called "dissociative hysteria." Due to this the dissociative disorders had difficulty shaking the suspicion that they were not true disorders, or that they were a disguise for secondary gain, malingering, or criminality. In 1980 the dissociative disorders were separated from hysterical neurosis and gained independent status. Since then PTSD and the dissociative disorders have developed in a somewhat parallel fashion. Its link with trauma has given dissociation an opportunity to be examined in relation with PTSD studies. Contemporary psychological and psychiatric sciences have used the term dissociation to denote alterations in conscious experience, a breakdown in integrated information processing and psychological functioning and the operation of multiple independent streams of consciousness. As a response to threat it manifests as a kind of body/mind problem that reflects in dysregulated brain functions that are rooted in critical developmental periods of life. Neuroimaging studies have shown neural systems which play an key role in emotion and autonomic nervous system regulation, sensory processing, attention and memory that exhibit altered levels of brain activation during dissociation, and are different from responses of `simple´ intrusions and hyperarousal – each representing unique pathways to chronic stress-related psychopathology. The phenomenology of traumatic dissociation is recognized in acute `narrow defined´ posttrauma reactions, but is also seen in cases classified as complex PTSD. Dissociation can be both symptom or a disorder, or a descriptive of a vulnerable phenotype. The complexity of trauma responses is revealed not in the complexity of the trauma, but in the multitude or spectrum of response types in which dissociative symptoms, but also depressive and somatization symptoms, substance abuse, eating disorders as well as general anxiety symptoms are present.

Eye Movement Desensitization and Reprocessing: Clinical Case Presentation

(Abstract #197560)

Master (Practice, Clin Res) **Salons 4-6, 3rd Floor**

Solomon, Roger, PhD[1]
[1]Buffalo Center for Trauma and Loss, Buffalo, New York, USA

Eye Movement Desensitization and Reprocessing (EMDR) is an integrative psychotherapeutic approach that conceptualizes current symptoms resulting from experiences that are inadequately processEd, that is, "frozen" in the brain). When these inadequately stored memories are triggered, symptoms result (e.g. nightmares, flashbacks, intrusive thoughts, etc.). The EMDR protocol involves accessing the dysfunctionally stored information, stimulating the innate processing system through standardized protocols (including eye movements), allowing it to transmute the memory to an adaptive resolution. Processing is evident by a rapid progression of intrapsychic connections as emotions, insights, sensations, and memories surface and change with each new set of bilateral stimulation. The mechanisms of action include adaptive information from other memory networks linking into the network holding the dysfunctionally stored information. There is a shifting of the information from implicit to episodic and then semantic memory. The memory is no longer isolated, and becomes appropriately integrated within the larger memory network. Hence, processing involves the forging of new associations and connections enabling learning to take place with the memory stored in a new adaptive form.

This presentation will discuss the eight phases, three-pronged, EMDR treatment model and illustrate the dynamics of treatment through a video case presentation.

Participant Alert: A taped session with a client who has experienced trauma will be presented.

Innovations in Experimental Psychopathology Research

(Abstract #196191)

Symposium/Panel (Res Meth, Clin Res) **Monroe Ballroom, 6th Floor**

Malta, Loretta S., PhD[1]; Karl, Anke, PhD[2]; Kleim, Birgit, PhD[3]; Milad, Mohammed R., PhD[4]; Rothbaum, Barbara O., PhD[5]; Davis, Michael, PhD[5]; Difede, Joann, PhD[1]; Ehlers, Anke, PhD[3]; Ehring, Thomas, PhD[6]; Houry, Debra, MD[5]; Leiberg, Susanne, PhD[7]; Myers, Karyn, PhD[5]; Orr, Scott P., PhD[8]; Pitman, Roger K., MD[4]; Rabe, Sirko, MA[9]; Rauch, Scott L., MD[4]; Shin, Lisa M., PhD[4]
[1]Weill Medical College of Cornell, New York, New York, USA
[2]University of Southampton, Southampton, England, United Kingdom
[3]Institute of Psychiatry, King's College London, London, England, United Kingdom
[4]Massachusetts General Hospital/Harvard Medical School, Boston, Massachusetts, USA
[5]Emory University School of Medicine, Atlanta, Georgia, USA
[6]University of Amsterdam, Amsterdam, Netherlands
[7]University of Zurich, Zurich, Switzerland
[8]Harvard Medical School/VA Medical Center, Manchester, New Hampshire, USA
[9]Saxonian Hospital, Grossschweidnitz, Germany

This panel will discuss innovations in PTSD experimental psychopathology research, including clinical and experimental analogue research on the role of cognitive factors in the development of PTSD; applications of the deficient extinction animal model of PTSD to early intervention and neuroimaging research; and novel uses of virtual reality and electrophysiology to test etiological models of PTSD.

Using Novel Technologies to Develop and Test Laboratory Models of PTSD
Malta, Karl, Leiberg, Rabe & Difede

This presentation discusses the use of novel technologies to study PTSD. Study 1 used EEG event-related potentials (ERPs) to investigate functional neuroanatomical changes associated with affective processing alterations in PTSD. A study with 110 treatment-seeking trauma survivors found that those with PTSD showed altered EEG responses to trauma-related stimuli in frontal brain regions, including increased P300 amplitude and decreased evoked EEG coherence between frontal and temporal areas in the theta band. The results suggest that ERPs and evoked coherence to trauma-related stimuli are useful complementary correlates of PTSD symptom severity. In study 2, veterans were presented with virtual reality (VR) combat scenarios, followed by either suppressing thoughts of the scenarios, or recounting events in the scenarios. One week later, volitional memory and intrusive memories of the scenarios were tested in surprise memory tests and a thought suppression task, respectively. PTSD re-experiencing symptoms, poorer initial encoding, and heart rate

variability during scenarios predicted more intrusive memories one week later. Predictors of volitional memory were general verbal memory and levels of anxiety and immersion during the scenarios. The results suggest that VR could be used to test laboratory models of PTSD re-experiencing symptoms.

Cognitively Oriented Experimental Approaches to Modeling PTSD Symptoms
Kleim, Ehring & Ehlers

This presentation discusses experimental approaches to modeling cognitive processes that may be involved in the etiology or maintenance of PTSD, using two examples, perceptual priming and rumination. First, Ehlers and Clark (2000) suggested that perceptual priming for trauma-related stimuli contributes to PTSD reexperiencing symptoms. Studies using word-stem completion and blurred pictures identification tasks found that enhanced priming for trauma-related stimuli was associated with PTSD. Experimental studies that used picture stories depicting traumatic scenes found that perceptual priming for stimuli from trauma-related picture stories was higher than for control stories and predicted intrusive memories. Second, it has been suggested that rumination maintains PTSD. Prospective studies showed that rumination predicts PTSD. Analogues studies found that experimentally induced rumination increases symptom levels. The findings suggest that a combination of two different types of paradigms appears fruitful: information-processing paradigms with clinical samples to establish a correlation between cognitive variables and PTSD; and experimental analogue studies testing the causal status of cognitive variables. Modeling particular aspects of PTSD symptoms may require the development of novel paradigms, as in the example of the priming experiments.

Clinical Translational Early Intervention Research Based on Animals Models of PTSD
Rothbaum, Davis, Myers & Houry

The initial symptoms of PTSD can be considered part of the normal reaction to trauma, but, those who suffer from chronic PTSD do not recover in the weeks and months following a trauma the way others do. Those with PTSD may not worsen, but they don't extinguish their original fear reactions. Therefore, PTSD can be viewed as a failure of recovery caused in part by a failure of fear extinction following trauma. Based on translational models of the consolidation of fear memories, we examine the effects of early interventional extinction training in an ultimate effort to know when it is best to intervene with humans following exposure to trauma to prevent the development of PTSD. The existing evidence suggests that 1) the debriefing literature is equivocal at best with some studies indicating it can cause harm, 2) there are no good candidates for immediate intervention; 3) the animal evidence suggests that some immediate extinction training can result in decreases in spontaneous recovery and renewal and reinstatement; 4) the animal evidence suggests that incomplete extinction training may cause sensitization, and finally; 5) the timing of extinction training after exposure/conditioning is crucial.

Deficient Extinction Retention in Posttraumatic Stress Disorder
Milad, Orr, Shin, Rauch & Pitman

Retention of fear extinction is thought to aid in recovery from a traumatic event. In the first study of this phenomenon, pairs of monozygotic twins discordant for combat exposure underwent a fear conditioning and extinction procedure. On Day 1, subjects viewed colored light stimuli, some of which were paired with mild electric shock, followed by extinction of the conditioned responses. On Day 2, recall of extinction learning was assessed. PTSD veterans had larger residual skin conductance responses than their own co-twins, and than the non-PTSD combat veterans and their co-twins, suggesting that retention of extinction of conditioned fear is deficient in PTSD, and that this deficit is acquired as a result of combat trauma leading to PTSD. In a second study, PTSD and non-PTSD singletons underwent the same procedure in a functional magnetic resonance imaging scanner. Extinction retention was again impaired in PTSD subjects. There was decreased ventromedial prefrontal cortical (vmPFC), and increased dorsal anterior cingulate cortical (dACC), activation in the PTSD group during extinction recall. vmPFC activity was positively correlated, and dACC negatively correlated, with magnitude of extinction retention. The findings suggest that a hyperactive dACC and a hypoactive vmPFC underlie the deficient extinction recall capacity in PTSD.

Interpersonal Victimization: Predictors, Consequences, and Clinical Intervention

(Abstract #196269)

Symposium/Panel (Practice, Clin Res) **Wabash Room, 3rd Floor**

Iverson, Katherine, MA[1]; Resick, Patricia, PhD[2]; Weatherill, Robin, PhD[3]; Vogt, Dawne, PhD[4]; Taft, Casey, PhD[5]; King, Lynda, PhD[6]; King, Daniel, PhD[6]; Dutton, Mary Ann, PhD[7]; Kilpatrick, Dean, PhD[8]; Cougle, Jesse, MSC[8]; Resnick, Heidi, PhD[8]; Cloitre, Marylene, PhD[9]
[1]National Center for PTSD, Boston VA Health Care System, Boston, Massachusetts, USA
[2]National Center for PTSD, Boston VA Healthcare System and Boston University, Boston, Massachusetts, USA
[3]National Center for PTSD, Boston VA Healthcare System, Jamaica Plain, Massachusetts, USA
[4]Boston University, Boston, Massachusetts, USA
[5]National Center for PTSD, Boston VA Healthcare System, Boston, Massachusetts, USA
[6]National Center for PTSD/VA Boston HealthCare System & Boston University, Boston, MA, USA
[7]Georgetown University, Washington, District of Columbia, USA
[8]Medical University of South Carolina, Charleston, South Carolina, USA
[9]NYU Child Study Center, New York, New York, USA

This symposium will focus on the emotional and physical health consequences of interpersonal aggression victimization, as well as issues related to violence revictimization and intervention. Data will be presented on predictors of sexual harassment among Marine recruits, emotional and physical health consequences of intimate relationship aggression, revictimization correlates among women from the National Women's Study, and treatment response of battered women to Cognitive Processing Therapy.

Military Sexual Harassment and Sex-Role Egalitarianism Among Marine Recruits
Military sexual harassment significantly affects the mental health and morale of troops. Sex-role egalitarianism, or beliefs about male and female roles, is predictive of attitudes toward interpersonal violence, including male to female partner violence. Individuals with more traditional, less egalitarian attitudes tend to be more tolerant of interpersonal and partner aggression. We examined whether sex-role egalitarianism was related to tolerance of military sexual harassment, victimization, and mental health outcomes in 1,489 Marine recruits (658 women and 831 men) who completed boot camp training at Parris Island. Sexual harassment was reported by 24% of men and 28% of women. Analyses indicated that greater egalitarianism was associated with less tolerance of harassment for both men ($r = -.31$, $p < .01$) and women ($r = -.16$, $p < .05$), and also with less victimization (men: $r = -.15$, $p < .01$; women: $r = -.26$, $p < .01$). Greater egalitarianism was also associated with fewer mental health symptoms (depression, anxiety, and PTSD). Results suggest that beliefs about sex roles are important to consider in efforts to reduce rates of military sexual harassment and possibly improve overall mental health. A model to test multivariate associations among these variables will be presented.

Long-Term PTSD Trajectories and Physical Health for Women Exposed to Intimate Partner Violence
The link between physical health and PTSD is well recognized. Three classes of 18-month trajectories of posttraumatic symptoms (PSS) were used to predict 18-month health outcomes in low-income, predominately African-American women exposed to intimate partner violence. SF-36 health outcomes are physical functioning (PF), pain (PP), role functioning (PRF) and global health

perception (GHP). Three PSS trajectories were (1) Recovery (high initial PSS followed by rapid and sustained recovery), (2) Resilient (initial and sustained sub-threshold PSS), and (3) Chronic (high initial and sustained PSS). Baseline level of IPV was used as a covariate. The Resilient group reported significantly better health outcomes compared to the Chronic group across all health measures ($t = 4.67$, $p < .000$, PF; $t = 2.84$, $p < .005$, PP; $t = 4.10$, $p < .000$ GHP; $t = 1.97$, $p < .05$, PRF). There were no differences between the Resilient and Recovery groups. In spite of early and large attenuation of PSS, the Recovery and the Chronic groups did not significantly differ on any health outcomes, except health perception ($t = 2.00$, $p < .05$). These data have implications for the long-term health effects of those with PSS, in spite of large and early symptom recovery.

Violent Victimization, PTSD Symptom Clusters
This longitudinal study addressed the question of whether exposure to potentially traumatic events (PTEs) involving interpersonal violence (IPV), other types of PTEs, and different PTSD symptoms clusters at baseline predict subsequent exposure to different types of PTEs at two year followup. Data from 3359 adult participants in the National Women´s Study (NWS) were used. At baseline, we measured history of IPV victimization, exposure to other PTEs, current PTSD, and other risk factors. Subsequent IPV victimization by non-intimate partners was predicted by previous IPV victimization and PTSD reexperiencing symptoms, but subsequent IPV victimization by intimate partners was predicted only by prior exposure to IV victimization. Subsequent exposure to other types of PTEs was predicted by history of IPV victimization and other PTEs as well as PTSD avoidance/numbing symptoms. Findings suggest that efforts to prevent exposure to new PTEs must understand different risks posed by different types of violence perpetrators and how different clusters of PTSD symptoms might influence risk in different situations.

Treatment Response of Battered Women With PTSD to Cognitive Processing Therapy
Few studies have examined the efficacy of interventions in reducing the negative mental health consequences of intimate partner violence (IPV) (Johnson & Zlotnick, 2006; Kubany et al., 2004). This study examined Cognitive Processing Therapy (CPT; Resick & Schnicke, 1992) for PTSD in a subset of women who endorsed past or current IPV (N = 90), and who were taking part in a larger evaluation of CPT (Resick et al., in press). In addition, predictors of treatment compliance were examined. Participants demonstrated significant reductions in PTSD symptoms, $F (1, 69) = 73.28$, $p < .001$, and depressive symptoms, $F (1, 69) = 57.24$, $p < .001$. These gains were maintained at a 6-month follow-up. Women who reported current IPV were more likely to drop out of treatment before the first session compared to those who did not endorse current IPV even after accounting for pretreatment PTSD and depressive symptoms. Additionally, the frequency of previous partner violent relationships was negatively predictive of treatment completion above and beyond pretreatment PTSD and depressive symptoms. The implications of these and other findings, including revictimization rates, will be discussed.

Mental Health in Children Following Hurricanes Katrina and Rita

(Abstract #196413)

Symposium/Panel (Child, Disaster) **State Ballroom, 4th Floor**

Jaycox, Lisa, PhD[1]; Walker, Douglas, PhD[2]; Cohen, Judith, MD[3]; Mannarino, Anthony, MD[3]; *Jones, Russell, PhD*[4]; Langley, Audra K., PhD[5]
[1]*RAND Corporation, Arlington, Virginia, USA*
[2]*Mercy Family Center, Metairie, Louisiana, USA*
[3]*Allegheny General Hospital, Pittsburgh, Pennsylvania, USA*
[4]*Virginia Polytechnic Institute and State University, Blacksburg, Virginia, USA*
[5]*UCLA, Los Angeles, California, USA*

Despite reports of widespread mental health problems following hurricanes Katrina and Rita, there is little information about children´s mental health needs or service delivery options. This panel draws from experiences in conducting research and delivery services to school children in New Orleans.

Hurricane and Trauma Exposure and Symptoms 15 Months Post-Hurricane
More than a year after the 2005 hurricanes, we assessed 195 school children about their hurricane experiences, other trauma exposure, PTSD and depressive symptoms, and also asked their parents and teachers to report on their behavior. Experiences of children in our sample included low rates of actual exposure to the hurricane dangers (e.g., having to walk through flood waters or get out by boat), but high rates of seeing upsetting things, separation from caregivers, and of loss. Our assessment of lifetime history of exposure to other traumas showed these were fairly common, particularly exposure to community violence and traumatic loss. We asked children which event bothered them the most: 38% reported it was the hurricanes, 26% reported it was a different traumatic event, and 15% reported that both the hurricane and a different event bothered them equally (21% reported that neither bothered them). In this presentation, we relate these trauma exposures to symptoms of PTSD and depression, as well as behavior problems, to elucidate which exposures are most related to mental health and behavioral problems. We discuss implications for identification of children at risk in the wake of future disasters.

A Stepped-Care Service Delivery Approach to Meeting Mental Health Needs of Children Post-Disaster
Project Fleur-de-lis™, created in October 2005, provides mental health services to children and families as a way to both heal and rebuild our community. The overall structure of Project Fleur-de-lis™ is a need-based stepped-care model with three tiers: early intervention for school-aged children, identification and provision of services to children in need within their schools, and increased access to best practices within our community mental healthcare system. Interventions include Classroom-Camp-Community-Culture Based Intervention (Macy, Macy, Gross & Brighton, 2006), Cognitive Behavioral Intervention for Trauma in Schools (Jaycox, 2003), and Trauma Focused – Cognitive Behavioral Therapy (Cohen, Mannarino & Deblinger, 2006). This collaborative program with 23,000 students beneath its umbrella of care will be described, including its implementation in 55 New Orleans area schools. Results of weekly Classroom – Community Consultation meetings for 678 children will be presented to show the types of problems that are being detected and the treatments ultimately received. The specific services offered at Mercy Family Center ($321,540 in free psychological or psychiatric care since September 1st 2006) will also be described. We discuss this innovative care system in terms of its potential applicability following other natural or man-made disasters.

Comparison of Two Approaches to Bringing Evidence-Based Care to School Children Post-Disaster
In a school-based intervention project conducted 15 months after hurricane Katrina, we identified 118 children with elevated

symptoms of PTSD and randomized them to either receive Cognitive Behavioral Intervention for Trauma in Schools (CBITS) or Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). These two interventions have many elements in common, but differ in some key aspects as well. In this study, both were offered free of charge. CBITS was delivered at school in groups, during the school day; whereas TF-CBT was offered at a local mental health clinic in parent-child dyads, by appointment. Despite intensive engagement and outreach efforts, only 21 of 60 students were evaluated for TF-CBT, and of those 14 were determined to be appropriate and began treatment, and XX of the initial 60 completed treatment. In contrast, 53 of 58 students completed CBITS at school. In this presentation, we discuss issues related to school-based screening and accuracy of PTSD identification, trade-offs in terms of intensity of treatment versus access, as well as thoughts about overcoming the barriers to clinic-based treatment that were so apparent in this project. We discuss these results in terms of disaster planning for long-term recovery for children.

Papers
Post-Deployment Adjustment in Veterans

Adams Ballroom, 6th Floor

Chair: Jenifer Strauss, PhD,
Duke University, Durham VA Medical Center, VISN 6 MIRECC, Durham, North Carolina, USA

Treating Veterans and Their Families: Are Practitioners Utilizing Evidence–Supported Practice?

(Abstract #195842)

Paper Presentation (Mil Emer, Clin Res)

Halpern, James, PhD[1]; Freeman, Phyllis R., PhD[2]
[1]Psychology, Institute for Disaster Mental Health, State University of New York at New Paltz, New Paltz, New York, USA
[2]Psychology, SUNY New Paltz, New Paltz, New York, USA

Clinical knowledge, professional practice, confidence, training needs, and suggestions for future research were examined in a sample of 132 community-based practitioners working with military personnel, recent veterans, and their families. Survey results indicated that most clinicians did not believe they had a sufficient understanding of military culture to be effective, nor consider themselves as familiar with the appropriate research literature on assessment and treatment. These clinicians do not appear to practice according to established best-practice guidelines, nor think it is important for them or for new colleagues to use techniques identified by these guidelines. They generally are not even "somewhat confident" in their ability to deliver services across a range of potential modalities and treatment domains. When asked about gaps in the research literature, responses clustered around six meta-themes: assessment and treatment, specific symptoms in military personnel, aspects of military culture affecting treatment and symptomatology, community and ecological factors, training, and families. A focus group of clinicians provided additional information on training and research gaps for the treatment of recent veterans and their families. Results provide suggestions for how best to disseminate clinical research findings to community-based practitioners.

Peer Support for Canadian Injured Soldiers and Their Families: The Results of a Needs Analysis

(Abstract #196152)

Paper Presentation (Commun, Mil Emer)

Lebeau, Mariane, MA[1]; Darte, Kathy, MN[2]; Cargnello, Juan, M.PS.[3]
[1]Department of National Defence, OSISS Co-Manager, Ottawa, Ontario, Canada
[2]Veterans Affairs Canada, OSISS Co-Manager, Charlottetown, Prince Edward Island, Canada
[3]Veterans Affairs Canada, Consultant Psychologist/ National Centre for Operational Stress Injuries, Sainte Anne-de-Bellevue, Québec, Canada

OSISS, a peer support program jointly sponsored by the Canadian Department of National Defence and Veterans Affairs Canada conducted a needs analysis of the social support required by Canadian soldiers seriously injured during operations in Afghanistan and their families. Using focus group methodology and structured interviews, a representative sample (33%) comprising of 26 of the seriously injured soldier population and a total of 8 family members participated in a needs analysis conducted in March 2007. The transcripts of the focus group meetings and interviews generated large quantities of qualitative data that addressed: (1) what source of social support they requirEd, (2) what would be the structure of the support; and, (3) who would provide peer support to injured soldiers and their families. Ten main themes (peer support, family support, home coming and recovery, assisting officers, medical care, and additional issues such as reservists, decompression, and the prioritizing of injuries) evolved from the content analysis along with 17 recommendations. This presentation will primarily focus on the process of the needs analysis utilized to obtain information on peer support as identified by injured soldiers and their families and discusses the recommendations and developments of the program that addresses their needs.

The Impact of Childhood Abuse and Combat-Related Trauma on Soldiers' Post-Deployment Adjustment

(Abstract #196168)

Paper Presentation (Mil Emer, Practice)

Mishkind, Matt, PhD[1]; Reger, Mark, PhD[1]; Gahm, Gregory, PhD[1]
[1]Madigan Army Medical Center, Tacoma, Washington, USA

The ongoing combat operations in Iraq and Afghanistan have given rise to a new generation of research examining the development of psychiatric difficulties following combat experiences as well as pre-military factors such as childhood physical abuse (CPA) that may affect post-deployment adjustment (Cabrera et al., 2007; Iverson, et al., 2007). This retrospective review study examined the additive and independent effects of CPA and combat-related trauma on post-combat psychiatric difficulties in an outpatient clinical sample (N =1045) of active duty Iraq and Afghanistan veterans. A one-way multivariate analysis of variance (MANOVA) was performed to examine trauma exposure group (i.e., no trauma, CPA only, combat only, or both) differences on four psychiatric outcome variables. Veterans exposed to both CPA and combat had the highest reported concerns for alcohol use, anxiety, depression, and PTSD symptoms ($F(12,2747) = 16.15$, $p<001$). Veterans exposed to either CPA or combat reported similar levels of concern for alcohol use, anxiety, and PTSD, with depression scores significantly higher for those exposed only to CPA. These findings support recent research examining the relationship between pre-military and combat traumas, and further elucidate the independent impact that CPA and combat may have on psychiatric concerns. Implications will be discussed.

A Novel Self-Management Intervention for PTSD Related to Military Sexual Trauma: Early RCT Findings

(Abstract #196106)

Paper Presentation (Clin Res, Mil Emer)

Strauss, Jennifer, PhD[1]; Jeffreys, Amy, MSTAT[1]; Almirall, Daniel, PhD[1]; Marx, Christine, MD, MA[1]; Morey, Rajendra, MD, MS[1]; Oddone, Eugene, MD, MHSC[1]
[1]Duke University, Durham VA Medical Center, VISN 6 MIRECC, Durham, North Carolina, USA

Purpose: Military sexual trauma (MST) entails harassment or sexual assault during military service. Over 50,000 women with MST have been identified, with more expected from current conflicts. to address this growing need, we developed the clinician-facilitated, self-management Guided Imagery for Trauma (GIFT) intervention. We report findings from an ongoing RCT in women veterans with PTSD related to MST.

Methods: The GIFT group receives audio instructions for relaxation, emotion regulation, and the creation of positive mental imagery, beliefs, and feelings. Controls receive relaxing music audios. All have regular contact with a clinician facilitator (2 sessions + weekly phone). The Clinician Administered PTSD Scale (CAPS) is the primary outcome.

Findings: As enrollment is ongoing (current N=20), no inferential statistics are reported here. Average age = 44.51(10.63); 60% African American, 35% Caucasian; average years since trauma = 22.3 (10.76). For GIFT, average pre-post reduction on the CAPS is 32.17 (d = 1.64). For Controls, average pre-post reduction is 17.67 (d = 0.95). We anticipate reaching our target enrollment (N = 38) by the 2008 ISTSS meeting.

Conclusions: Initial results indicate that GIFT reduces PTSD symptoms. If shown efficacious, this novel intervention may improve our ability to provide needed care to women with MST.

Papers

Trauma Treatment in Conflict Zones

Crystal Room, 3rd Floor

Chair: Pim Scholte, MD,
Dept. of Psychiatry, University of Amsterdam, Academic Medical Center, Amsterdam, Netherlands

Community Based Sociotherapy in Rwanda; Its Effects on Mental Health

(Abstract #196299)

Paper Presentation (Clin Res, Civil Ref)

Verduin, Femke, MD[1]; Scholte, Pim, MD[1]
[1]Dept. of Psychiatry, University of Amsterdam, Academic Medical Center, Amsterdam, Netherlands

From 1990 to 1994, Byumba region in the North of Rwanda was terrorized by war and a subsequent genocide. Its population still suffers from the sequelae of collective traumatization. Since January 2006, a community based sociotherapeutic intervention is carried out in the region, aiming to reduce mental suffering and to restore safety and dignity. 3800 individuals have participated in sociotherapy groups so far. We studied the intervention´s effects on mental health by use of the Self Reporting Questionnaire 20 item version (SRQ-20). As the SRQ-20 is not commonly used as an instrument to follow up respondents, we not only established its local validity as a screener but also its longitudinal validity. We then followed a prospective randomized controlled design to study a sample consisting of 90 sociotherapy group participants, 83 closely related individuals and 94 controls. Measures were taken at group entry (T0, October 2007), after termination of the meetings (T1, January 2008), and at 6 months follow-up (T2, August 2008). The intervention seems to positively impact mental health. In group participants there is a slight but significant drop of SRQ scores at T1. In those who at T0 score above the locally established cut-off point of 10, scores dropped with 3.2 to below cut-off at T1. In this presentation outcomes of the 6 months follow-up will be presented as well.

Community Based Sociotherapy in Rwanda; Its Effects on Social Functioning and Social Capital

(Abstract #196293)

Paper Presentation (Clin Res, Civil Ref)

Scholte, Pim, MD[1]; Verduin, Femke, MD[1]
[1]Dept. of Psychiatry, University of Amsterdam, Academic Medical Center, Amsterdam, Netherlands

From 1990 to 1994, Byumba region in the North of Rwanda was terrorized by war and a subsequent genocide. Its population still suffers from the sequelae of collective traumatization. Since January 2006, a community based sociotherapeutic intervention is carried out in the region, aiming to reduce mental suffering and restore social bonds. 3800 individuals have participated in series of 15 weekly sociotherapy group meetings so far. Following a prospective randomized controlled design, we established the intervention´s effects on social functioning by use of the MOS SF-36 and a locally informed structured interview (BSFQ), and its effects on social capital by use of the short adapted version of the Social Capital Assessment tool (SA-SCAT). Instruments were adapted and validated locally. We studied a sample consisting of 90 sociotherapy group participants, 84 closely related individuals and 91 controls. Measurements were carried out at group entry (T0, October 2007), and after termination of the meetings (T1, January 2008); a 6 months follow-up (T2) will take place in September 2008. In this presentation the concept of social capital and the adaptation and validation process of instruments will be discussed, as well longitudinal outcomes, and the seeming value of this intervention for the healing process at individual and community level in war-affected populations.

Traumas and Transformational Coping Mechanisms Among Japanese American Hiroshima/Nagasaki Survivors

(Abstract #195971)

Paper Presentation (Disaster, Cul Div)

Ikeno, Satoshi, PhD[1]; Nakao, Kayoko, MSW[2]
[1]Department of Social Work, Kwansei Gakuin University, Nishinomiya, Japan
[2]Department of Social Welfare, University of California, Los Angeles, Los Angeles, California, USA

This study examines the consequences of coping with A-bomb traumas and long-term transformational effects among Japanese American Hiroshima/Nagasaki survivors. We analyzed 23 transcribed life review interviews with self-identified Japanese American A-bomb survivors in Southern California. We first identified shared experiences across the participants that were unique to 'Japanese-American" A-bomb survivors. Immigration patterns emerged as the group-specific life event that consequently exposed them to the A-bomb trauma. The microanalysis of the transcripts identified culturally-specific coping mechanisms that helped them with enduring multi-dimensional hardships throughout the life-course. "Shikataganai (It cannot be helped)" emerged as the most recurring coping style that embraces negative emotions such as loss, grief, and anger derived from the traumatic event. Remorse for being helpless during the A-bomb attack and feelings of guilt as a survivor surfaced as the event-specific emotions attached to the lucid memory of the war. Spiritual and political meaning attribution to the A-bomb experience was notable, suggesting symbolic transformation of

the A-bomb trauma to an all-encompassing life event with age. We will discuss practice implications for assisting immigrant disaster survivors, particularly those in old age, and implications for future research.

Posttraumatic Growth Following the Disengagement: A Longitudinal Study of the Gaza Settlers

(Abstract #196328)

Paper Presentation (Civil Ref, Disaster)

Hall, Brian, MA[1]; Palmieri, Patrick, PhD[2]; Halperin, Eran, PhD[3]; Canetti-Nisim, Daphna, PhD[4]; Hobfoll, Stevan, PhD[5]
[1]Psychology, Kent State University and the Kent/Summa Center for the Treatment and Study of Traumatic Stress, Stow, Ohio, USA
[2]Summa Health System and the Kent State/Summa Center for the Treatment and Study of Traumatic Stress, Akron, Ohio, USA
[3]Department of Psychology and Stanford Center on International Conflict and Negotiation, Stanford University, Stanford, California, USA
[4]Political Science, University of Haifa and Yale University, Haifa, Israel
[5]Kent State University and the Kent/Summa Center for the Treatment and Study of Traumatic Stress, Kent, Ohio, USA

Prospective investigations have shown that posttraumatic growth (PTG) increases over time and that PTG is related to less psychological distress. This was investigated in a longitudinal study of 103 Israeli settlers assessed in the process of, and one year following, the Gaza disengagement. PTG was assessed in relation to terrorism exposure and disengagement stressors at both time points. Significant PTG was reported (T1=93%, T2=84%). Greater intimacy with family (T1=69%, T2=59%) and greater meaning (T1=63%, T2=40%) were the most commonly reported types of growth. Results of paired t tests indicated that a significant decrease in PTG occurred between baseline and follow-up assessment, t(102)= 4.80, p<.001. Four PTG groups were created using the median of PTG at T1 and T2: always low PTG, increased PTG, decreased PTG, and always high PTG. Results of one way ANOVAs indicated significant group differences for post-disengagement PTSD symptoms (F(3, 99)=7.89, p<.001) and depression symptoms (F(3, 99) = 5.16, p < .001). Post-hoc tests indicated that settlers in the increased PTG group reported significantly greater PTSD and depression than settlers in the always low PTG and decreased PTG groups. Contrary to prior studies, PTG decreased and settlers who used PTG to cope following the disengagement experienced greater distress.

Papers

Emotion, Sensitivity, and Regulation

Salon 1, 3rd Floor

Chair: Matthew Kimble, PhD,
Psychology, Middlebury College, Middlebury, Vermont, USA

Emotion Regulation Difficulties in Survivors of Type I and Type II Traumas

(Abstract #196235)

Paper Presentation (Clin Res, Asses Dx)

Ehring, Thomas, PhD[1]
[1]Department of Clinical Psychology, University of Amsterdam, Amsterdam, the Netherlands, Netherlands

Emotion regulation difficulties have been suggested to be common sequelae of traumatic experiences, especially type II traumas. However, empirical evidence for this hypothesis is limited. Two studies investigating emotion regulation difficulties in trauma survivors will be presented.

In study 1, survivors of different types of traumatic events (n = 483) and non-traumatized controls (n = 48) filled in questionnaires assessing difficulties in emotion regulation. Results showed that survivors of type II traumas reported significantly higher levels of emotion regulation difficulties than type I trauma survivors and controls. In addition, regardless of the type of trauma experienced, a diagnosis of PTSD was related to more severe emotion regulation problems. Study 2 assessed self-reported emotion regulation characteristics in 95 motor vehicle accident survivors 1 month post-trauma and symptom levels of PTSD at 1, 3, and 6 months. Difficulties in emotion regulation were significantly correlated with PTSD symptom severity and predicted symptom levels at follow-up.

Taken together, the results support the idea that emotion regulation difficulties are a common consequence of traumatic experiences and are correlated with PTSD symptom severity. Implications for theoretical models of trauma-related disorders and future research will be discussed.

Attention Bias Among Interpersonal Violence Survivors: A Comparison of Stroop and Dot Probe Paradigms

(Abstract #196479)

Paper Presentation (Asses Dx, Clin Res)

Scher, Christine D., PhD[1]; Ellwanger, Joel, PhD[2]
1California State University, Fullerton, California, USA
2California State University, Los Angeles, California, USA

Background: Attention biases have been repeatedly demonstrated among PTSD survivors. However, the literature examining such biases has typically utilized a single assessment paradigm (i.e., Stroop). This study builds upon current knowledge by examining attention biases using two paradigms and extending the literature to trauma survivors with subsyndromal symptom levels.
Method: Participants were 33 Criterion A interpersonal violence (IV) survivors and 27 persons who had not experienced IV. Participants completed a Stroop task with acoustic startle probes occurring 60 and 3500 ms following word onset and a dot probe task with startles occurring at 300 and 3500 ms following picture onset.
Results: MANOVAs examined group x stimulus valence interactions. For the Stroop, there were significant interactions for reaction time, F(1,55) = 4.84, p = .03, and startle modification, F(3,45) = 3.47, p = .02, indicating greater attention to trauma-related and negative words among the IV group. For the dot probe, there was an interaction trend for startle modification, F(2,42)= 3.06, p = .06, indicating greater attention to trauma-related and negative words in the IV group. Results suggest the Stroop may more sensitively assess processing biases and that the biases found among PTSD survivors are also found among those with subsyndromal symptoms.

Does the Modified Stroop Effect (MSE) Exist in PTSD?

(Abstract #195900)

Paper Presentation (Asses Dx, Res Meth)

Kimble, Matthew, PhD[1]; Frueh, Chris, PhD[2]; Marks, Libby, BACANDIDATE[1]
[1]Psychology, Middlebury College, Middlebury, Vermont, USA
[2]Psychology, University of Hawaii, Hilo, Hawaii, USA

The modified Stroop effect (MSE), in which participants show delayed color naming to trauma-specific words, is one of the most established findings pertaining to the cognitive effects of PTSD. Yet, the actual effect may not be as robust as has been suggested. The current study used a novel approach (Dissertation Abstract Review; DAR) to review the presence or absence of the MSE in published dissertation abstracts. DAR has the advantage of minimizing selection bias associated with the "file drawer effect" in which studies with null effects are rarely published. A review of all dissertations that used the MSE in a PTSD sample revealed that only 8% (1 of 12) of the studies found delayed reaction times to trauma-specific words in participants with PTSD. The most common finding (75%) was for no PTSD-specific effects in color naming trauma-relevant words. This ratio is significantly different

than the ratios found in peer-reviewed journals. Within the peer reviewed literature, studies reporting "positive" MSE effects were published in higher impact journals than those reporting "negative" findings—a bias we refer to as the "top drawer effect." These data suggest a re-evaluation of the modified Stroop effect in PTSD is warranted.

The Relation Between PTSD and Sensitivity to Emotional Context

(Abstract #196288)

Paper Presentation (Asses Dx, Clin Res)

Milanak, Melissa E., BA[1]; Berenbaum, Howard, PhD[2]
[1]Psychology, University of Illinois at Urbana Champaign, Champaign, Illinois, USA
[2]Psychology, University of Illinois at Urbana-Champaign, Champaign, Illinois, USA

The relation between PTSD and sensitivity to emotional context was examined in 90 university students (72% female) with trauma histories, of whom 18% had PTSD. Participants completed a facial affect recognition task in which faces displaying emotional expressions were superimposed upon emotionally valenced and neutral images (e.g., happy – a parade; sad – a coffin; neutral – a lamp). Participants decided which emotion the facial display was expressing. A 3 (Context Condition: Matching vs. Mismatching vs. Neutral) x 2 (PTSD: Present vs. Absent) repeated measures ANOVA revealed a significant Context Condition x PTSD interaction, F (2,87) = 3.70, p < .05, eta2 = .08. Both groups were more accurate at recognizing facial expressions when the context emotion matched the face emotion than when the context emotion did not match the face emotion. However, individuals with PTSD were more strongly affected by the emotional context than were individuals without PTSD. Specifically, individuals with PTSD performed better than controls when context and face emotion matched (t (88) = -2.09, p < .05) and performed worse than controls when context and face emotion mismatched (t (88) = 1.75, p = .08). These results suggest that individuals with PTSD have heightened sensitivity to emotional context.

Participant Alert: Some images that are negatively emotionally valenced (e.g., a gun or an angry dog) may be upsetting to some viewers.

Papers
Sexual Assault

Salon 3, 3rd Floor

Chair: William F. Flack, Jr., PhD,
University, Lewisburg, Pennsylvania, USA

Are Different Types and Tactics of Sexual Assault Associated With More Deleterious Outcomes?

(Abstract #195905)

Paper Presentation (Res Meth, Clin Res)

Zayed, Maha, MA[1]
[1]Northern Illinois University, DeKalb, Illinois, USA

Using a modified version of the Sexual Experiences Survey (SES), we examined whether the consequences of adult sexual assault (ASA) vary depending on the type of ASA (contact, attempted intercourse, intercourse) and the tactics used by the perpetrator (arguments/pressure, authority, alcohol/drugs, physical force) after controlling for a history of trauma. College women (N= 654) completed a modified SES and self-report measures of depression, anxiety, PTSD, fear, self-blame, self-efficacy, and shame and guilt. Intercourse was associated with highest symptom levels of any form of ASA, and attempted intercourse was associated with the lowest symptom levels of any form of ASA. Attempted intercourse was associated with greater self-efficacy for potential ASA situations, compared to intercourse. ASA involving authority was associated with the highest levels of mental health symptoms and the highest levels of self-blame, of all the perpetrator tactics, whereas ASA involving force was associated with the lowest levels of anxiety, depression, and self-blame but the second highest levels of PTSD. Implications for theory, research, and treatment are discussed.

Posttraumatic Symptoms Related to Unwanted Sexual Experiences Among College Students

(Abstract #195869)

Paper Presentation (Clin Res, Sos Ethic)

Flack, Jr., William F., PhD[1]
[1]Bucknell University, Lewisburg, Pennsylvania, USA

This study was designed to examine the relationship between unwanted sexual experiences (USE) and posttraumatic symptoms (PTS) in the collegiate "hook-up" culture (characterized by sexual encounters without future relational commitment). A representative sample of 205 undergraduate students (121 women, 84 men) completed a survey on their experiences of unwanted sexual touching (UST), attempted unwanted sex (AUS; anal, oral, or vaginal), and completed unwanted sex (CUS; anal, oral, or vaginal) based on the revised Sexual Experiences Survey (Koss, Bachar et al., 2004), and PTS related to their worst or only USE based on the PTSD Checklist-Civilian Version (Weathers et al., 1994). Among women (men reported very few UST, no other USE, and almost no PTS), 29.8% reported UST, 8.3% of whom reported minimum diagnostic criterion PTS levels (ratings of "3/moderate" or higher for at least 1 B, 3 C, and 2 D cluster symptoms); 25.6% reported AUS, of whom 9.7% reported criterion PTS; and 9.9% reported CUS, of whom 16.7% reported criterion PTS, all during a reference period of less than two years. Almost all USE occurred during hook-ups, underscoring the importance of further examining this currently popular context of intimacy.

Sexual Abuse and Help Seeking Patterns in Turkey

(Abstract #196499)

Paper Presentation (Practice, Cul Div)

Yuksel, Sahika, MD[1]; Sezgin, Ufuk, PhD[2]; Bikmaz, Sevda, MD[3]
[1]Istanbul Medical University, Istanbul, Turkey
[2]Kocaeli University, Izmit, Turkey
[3]Istanbul Medical Faculty, Istanbul, Turkey

Sexual abused (SA) women have difficulty to disclose their trauma. These late disclosure also are barriers for medical and legal help seeking.

Method: 80 women with a SA history were admitted to Istanbul PSTP and they were evaluated with Semistructured Trauma Assesment From PDS (Foa 995) and IES- R (Marmor etal 1996).

Findings: The patients were in between 15–59 years old (m:25.8+ 10.2), 35% of them were married. Although after SA some women have told their trauma immediately to their informal network, only 14% of them have reported and requested treatment in the first month. Most of them (73,6%) were admitted with their own will for treatment, 18,6% of them were admitted with the force of family 28.8 % of 4 them were requested a forensic report. During intake interview it was noticed that all needs treatment and have a diagnosis of at least one psychiatric disorder and were recommended treatment. But half of the group (48.2%) neither never started treatment nor left the treatment in the early stage.

Discussion: The barriers of low rate of medical and legal help seeking behaviors will be discuss in cultural context of a conservative country.

Is Sexual Assault Disclosure Therapeutic? Comparing Lab Versus Field Study Results

(Abstract #195958)

Paper Presentation (Clin Res, Sos Ethic)

Ullman, Sarah E., PhD[1]
[1]*Criminal Justice, University of Illinois at Chicago, Chicago, Illinois, USA*

Trauma disclosure has been hypothesized to be therapeutic and lead to positive physical and psychological effects (Pennebaker et al., 1988). Few traumas in experimental studies of the effects of trauma disclosure involve sexual victimization. This presentation reviews and compares both lab and field studies on sexual assault disclosure to assess the evidence regarding the potential therapeutic effects of disclosure. Unlike the experimental lab studies of college students disclosing trauma in the lab, the few experimental studies of sexual assault and abuse disclosure have not shown positive effects. Results of field studies of sexual assault trauma disclosure show some positive effects of disclosure, contingent on timing, nature, and social context, including social responses to disclosure. Possible explanations for discrepant findings between lab and field studies are presented and suggestions are provided for future research in this area.

Papers
PTSD After Mass Shootings and Disasters

Salons 7 – 9, 3rd Floor

Chair: Holly Orcutt, PhD,
Northern Illinois University, De Kalb, Illinois, USA

Anxiety Sensitivity and PTSD Symptom Severity Following the NIU Shootings on February 14, 2008

(Abstract #196238)

Paper Presentation (Disaster, Prev EI)

Stephenson, Katherine, BA[1]**; Valentiner, David, PhD**[1]**; Orcutt, Holly, PhD**[1]**; Rabenhorst, Mandy, PhD**[1]**; Matuszewich, Leslie, PhD**[1]
[1]*Psychology, Northern Illinois University, DeKalb, Illinois, USA*

Two weeks following a mass trauma, 416 female college students that had previously been assessed for PTSD symptoms completed questionnaires. These questionnaires included the Anxiety Sensitivity Index – 3 (ASI-3; Taylor et al., 2007), the Distressing Event Questionnaire (DEQ; Kubany et al., 2000), and measures of physical and psychological proximity. Ninety-six of these students reported having been in the building where the shootings took place, seeing the gunman or wounded or killed shooting victims, and experiencing fear, helplessness, or horror. Analyses will examine the unique association of ASI-3 scales in predicting PTSD symptom severity, controlling for prior PTSD symptoms. We will also examine whether DES avoidance symptoms are uniquely predicted by the interaction between total ASI-3 scores and DES physiological arousal scores. These analyses are expected to help us understand whether distinct facets of anxiety sensitivity are especially relevant to the development of acute stress symptoms, and whether avoidance and numbing symptoms can be understood as resulting from an avoidance of physiological symptoms among individuals who find such symptoms to be highly aversive.

Participant Alert: This paper includes a brief description of and references to the mass shooting trauma on the NIU campus on February 14, 2008.

Experiential Avoidance as a Risk Factor for PTSD Symptoms Following a Mass Shooting

(Abstract #196526)

Paper Presentation (Disaster, Prev EI)

Orcutt, Holly, PhD[1]**; Varkovitzky, Ruth, BS**[1]**; Hattula, Mandy, MA**[1]**; Rabenhorst, Mandy, PhD**[1]**; Valentiner, David, PhD**[1]
[1]*Northern Illinois University, De Kalb, Illinois, USA*

Experiential avoidance (EA) involves an unwillingness to remain in contact with negative private events, as well as steps taken to alter the form or experience of these events. Theory and research suggest that EA may underlie symptoms of PTSD, and empirical evidence suggests that EA functions as a mediator of the relationship between traumatic experiences and distress. Previous research is limited by a lack of pre-trauma assessment of EA, which reduces the degree to which EA can be understood as a risk factor for PTSD. The present study aims to examine the prospective relationship between EA and PTSD symptoms among survivors of the mass shooting that occurred at Northern Illinois University on February 14, 2008. Previous trauma history and pre-trauma EA were assessed at Time 1 (pre-shooting) among 820 undergraduate females. Level of exposure to the mass shooting and traumatic stress symptoms were measured in a post-trauma assessment that was launched March 2, 2008. As of March 14, 2008, follow-up assessments were available for 446 participants, with data collection ongoing. Pre-shooting trauma history and EA are hypothesized to predict functioning post-shooting. Intensity of trauma exposure is predicted to moderate the relationship between EA and Time 2 traumatic stress symptoms.

Impact of Exposure to Trauma on PTSD Symptomatology in Swedish Tsunami Survivors

(Abstract #196388)

Paper Presentation (Disaster, Clin Res)

Bergh Johannesson, Kerstin, PsyD[1]**; Michel, Per-Olof, MD, PhD**[2]**; Hultman, Christina, PhD**[3]**; Lundin, Tom, MD, PhD**[1]
[1]*Department of Neuroscience, Uppsala University, National Center for Disaster Psychiatry, Uppsala, Sweden*
[2]*National Center for Disaster Psychiatry, department of Neuroscience, Uppsala, Sweden*
[3]*Karolinska institutet, Stockholm, Sweden*

The aim was to examine long-term mental health and posttraumatic stress symptomatology in a Swedish tourist population after exposure to the 2004 Southeast Asian tsunami. Data from 4822 returned questionnaires 14 months after the disaster were analysed. Respondents were categorised into three subgroups: (1) danger-to-life exposure group (having been caught or chased by the waves), (2) non- danger-to-life exposure group (exposed to other disaster-related stressors) and (3) low exposure group. Main outcome measures were GHQ-12 and IES-R. Danger-to-life exposure was an important factor in causing more severe Posttraumatic stress symptoms and in affecting mental health. Female gender, single status and former trauma experiences were associated with greater distress. Other factors related to more severe symptoms were loss of relatives, physical injuries, viewing many dead bodies, experiencing life threat and showing signs of cognitive confusion. Disaster exposure has a substantial impact on survivors, which stresses the need for long-lasting support.

A Community Psychology Program for Meeting the Needs of the Elderly Following the Kashmir Earthquake

(Abstract #196047)

Paper Presentation (Disaster, Commun)

Dodge, Gordon, PhD[1]; Sarwar, Naeem, MS[2]
[1]Gordon R. Dodge, PhD, LP and Associates, Forest Lake, Minnesota, USA
[2]Merlin-Helpage, Islamabad, Pakistan

The Kashmir earthquake killed an estimated 80,000 people and severely affected over 3 million others. Two NGOs,namely Merlin and Helpage, conducted a joint community-based program to meet the psychosocial recovery needs of the population they were serving, with emphasis on reaching the elderly. Utilizing community psychology principles and methods a range of services were provided, including training of local and NGO providers in psychosocial assessment and intervention methods,education, community mobilization, and capacity-building. Pre and post intervention measurements were conducted through the use of community analysis as well as screening instruments (BDI, IES-R, & GHQ-12), with significant improvements documented in the elderly, in the villages as well as in the IDP camps. The results of this program support the premise that significant psychological therapeutic benefits can be achieved with a large population following a disaster through the development and utilization of basic community resources, institutions, and activities. This program also provided an opportunity to conduct a range of evaluation procedures and develop recommendations for future similar disaster response programs and the evaluation of such.

The Core Concepts, Skills, and Components Curriculum: Increasing Trauma Expertise in Practitioners

(Abstract #196349)

Workshop/Case Presentation (Media Ed, Child) **Salon 2, 3rd Floor**

Layne, Christopher, PhD[1]; Gewirtz, Abigail, PhD[2]; Ghosh Ippen, Chandra, PhD[3]; Dominguez, Renee, PhD[4]; *Abramovitz, Robert, MD*[5]; Stuber, Margaret, MD[6]
[1]UCLA - National Center for Child Traumatic Stress, Los Angeles, California, USA
[2]Dept. of Family Social Science & Institute of Child Development, University of Minnesota, Minneapolis, Minnesota, USA
[3]Child Trauma Research Project, San Francisco General Hospital, San Francisco, California, USA
[4]Chicago Child Trauma Center (CCTC), La Rabida Children's Hospital, Chicago, Illinois, USA
[5]Jewish Board of Family and Children´s Services, New York, New York, USA
[6]Semel Institute for Neuroscience and Human Behavior, University of California Los Angeles, Los Angeles, California, USA

This workshop will provide an overview of the Core Concepts, Skills, and Components Curriculum (CCSCC), which is currently being developed by the Core Curriculum for Child Trauma Task Force of the National Child Traumatic Stress Network. Workshop content will include a description of (a) the aim and intended uses of the Curriculum in raising the standard of care provided to trauma-exposed children and adolescents; (b) the structure of the curriculum, as organized around core concepts (why we intervene as we do with our clients), intervention components (what we do with our clients), and skills (how we implement those components), in addition to cross-cutting issues including developmental factors, cultural factors, the empirical evidence base, and adaptation and implementation considerations. The workshop will also address (c) ways in which the Core Curriculum will use problem-based active learning methods to facilitate the acquisition of professional expertise in practitioners working with trauma-exposed youth and their families; and (d) presentation of a clinical case vignette that highlights the application of principles of problem-based learning to enhance expert knowledge and clinical judgment.

Participant Alert: Workshop authors will present clinical case vignettes that involve exposure to child and adolescent trauma, including sexual or physical abuse and witnessing serious physical injury.

Concurrent Session 9
Friday, November 14
3:30 p.m. – 4:45 p.m.

DSM-V
Should the Trauma Criteria be Retained or Revised?

The Criterion A Problem: On the Past, Present, and Future of the Stressor Criterion for PTSD

(Abstract #197922)

DSM-V (Asses Dx, Res Meth) **Grand Ballroom, 4th Floor**

Weathers, Frank, PhD[1]
[1]*Auburn University, Auburn, Alabama, USA*

Considerable controversy has surrounded Criterion A, the stressor criterion for posttraumatic stress disorder (PTSD), since PTSD was first introduced in *DSM-III* in 1980. This presentation will summarize the various issues, challenges, empirical findings, and proposed solutions regarding the appropriate role of Criterion A. The following points will be argued: First, psychological trauma is difficult to define, and the goal of achieving a succinct, unambiguous, universally accepted definition may be unrealistic. Second, although Criterion A has evolved considerably since *DSM-III,* the underlying conceptualization of trauma has remained stable. Third, when the criterion language and accompanying text are considered together, the *DSM-IV* version of Criterion A provides a practical definition of trauma that provides a sufficiently stringent threshold of stressor severity while allowing for requisite clinical judgment. Fourth, Criterion A is essential to the current conceptualization of PTSD as a stress-related disorder and crucial for differential diagnosis of PTSD, especially vis a vis adjustment disorder. Finally, many of the anomalous empirical findings concerning trauma exposure and PTSD are likely the result of insufficiently specific assessment methods. Suggestions will be offered regarding revision of Criterion A for *DSM-V* and methodological improvements in assessment of trauma and PTSD.

Defining Criterion A: Philosophical and Empirical Controversies

(Abstract #197593)

DSM-V *(Asses Dx, Res Meth)* **Grand Ballroom, 4th Floor**

Kilpatrick, Dean, PhD[1]
[1]*Medical University of South Carolina, Charleston, South Carolina, USA*

The stressor criterion, or Criterion A, plays a major gatekeeping role in the PTSD diagnosis because it determines which events qualify to be evaluated with respect to other PTSD criteria. How broadly or narrowly Criterion A should be defined has generated controversy since the birth of the PTSD diagnosis, and each revision of the diagnosis has included a different definition of Criterion A. In particular, the *DSM-IV* definition of Criterion A has been criticized as facilitating "bracket creep" (McNally & Breslau, 2008). This presentation will argue that the controversy over how Criterion A should be defined involves philosophical as well as empirical questions. The philosophical question is whether there is utility in excluding some types of stressor events from Criterion A if they are demonstrated to be capable of producing sufficient PTSD symptoms to meet Criterion B, C, D and F. The empirical question is whether "bracket creep" is a real or a pseudo problem. If there is a substantial increase of PTSD prevalence defined as meeting Criteria, B, C, D, E, and F when stressors do not meet the Criterion A1 and/or A2 definition, then there would be empirical support for the "bracket creep" argument. However, if there is little change in PTSD prevalence when such stressor events are included, "bracket creep" would be a pseudo problem from an empirical perspective. A second empirical question is how to measure PTSD when an individual has been exposed to numerous potentially traumatic events and other stressors. These questions will be addressed using two large epidemiological national probability household samples of U.S. young adults and adolescents in which exposure to potentially traumatic events, other life stressors, and PTSD symptomatology were measured. Implications for changes in the Criterion A definition will be discussed.

Traumatic Events Should Meet Either Criterion A1 or A2 Not Both

(Abstract #197571)

DSM-V (Asses Dx, Bio Med) **Grand Ballroom, 4th Floor**

Brewin, Chris, PhD[1]
[1]*Clinical, Educational and Health Psychology, University College, London, United Kingdom*

Stressor criterion A2 was added to the *DSM-IV* so that in order to qualify for a diagnosis of PTSD potentially traumatic events had to fulfill both objective and subjective criteria. Research with crime victims has shown that extreme fear, helplessness or horror often but not invariably accompany events leading to PTSD. Delayed onset PTSD in military samples is associated with less extreme subjective responses to trauma than cases of immediate onset PTSD while otherwise being indistinguishable in terms of symptom profile. In contrast, A2 responses are sometimes associated with the full PTSD symptom profile in the absence of an event that would meet the objective criterion A1. This is to be expected given what is known about the ability of stress responses to be sensitised biologically by exposure to early or repeated trauma. A solution that could be implemented in *DSM-V* is for potentially traumatic events to be required to meet either criterion A1 or A2, rather than having to meet both criteria as they do at present.

Do We Need Criterion A2?

(Abstract #197592)

DSM-V (Asses Dx, Res Meth) **Grand Ballroom, 4th Floor**

Schnurr, Paula, PhD[1]
[1]*VA National Center for PTSD, White River Junction, Vermont, USA*

In *DSM-IV*, the stressor criterion was modified in order to ensure that an individual who qualified for a diagnosis of PTSD had experienced a potentially traumatic event as traumatic. In essence, the modification—A.2—was to serve a gate-keeping function by preventing overdiagnosis among trauma survivors who had not had a serious subjective reaction to an event. In practice, there has been little need for a gate. The *DSM-IV* Field Trial data showed prevalence varied little as a function of whether the A.2 Criterion was applied. Other data show that although meeting A.2 in the immediate aftermath of a trauma predicts the development of PTSD, it is the absence of A.2 that matters: although a number of people who meet A.2 do not go on to develop PTSD, relatively few who fail to meet A.2 will develop PTSD. This presentation will examine the argument that A.2 is unnecessary for diagnosis, and will include discussion of how the absence of a strong subjective reaction can be useful in other contexts, such as predicting the need for future services. The presentation will also include discussion of definitional issues, including whether other strong reactions such as shock or numbing should be included.

Constructing Terror: Traumatization of Detained Terror Suspects

(Abstract #195961)

Symposium/Panel (Sos Ethic, Mil Emer) **Crystal Room, 3rd Floor**

Aronson, Eric, PsyD[1]; **Conroy, John**[2]; **Fletcher, Laurel, JD**[3]; **Olson, Brad, PhD**[4], **Smith, Stephen, MA**[5]

[1]*Amnesty International USA, Chelmsford, Massachusetts, USA*
[2]*Freelance Journalist, Oak Park, IL USA*
[3]*Boalt Hall School of Law, University of California at Berkeley, Berkeley, California, USA*
[4]*Human Development and Social Policy, Northwestern University, Evanston, Illinois, USA*
[5]*Oakland, California, USA*

New information obtained through investigative journalism, interviews and legal proceedings clarifies factors that contribute to detainee abuse and the role of health professionals; how detainees cope with Trauma, and immediate and long-term consequences for those involved – victims, perpetrators and bystanders – and for society.

The Torturer Speaks: A Journalist's Interviews With Former Torturers
Who becomes a torturer? How do torturers rationalize their acts? Do they feel for their victims? How might the behavior be prevented in the future? This presentation will address the individual perpetrator, presenting excerpts from interviews with torturers who look back on their acts and assess who is responsible for the trauma they inflicted.

Guantánamo and its Aftermath: A Study of Detainees Released From U.S. Custody at Guantánamo Bay
There has been a noticeable lack of systematic post-release studies of prisoners detained at Guantánamo Bay in Cuba. This two-year study of Guantánamo detainees who have left U.S. custody and returned to their countries of origin or other locations consists of: (1) in-depth, semi-structured interviews with approximately 60 former detainees from Europe, the Middle East, and Afghanistan; (2) key informant interviews with lawyers representing detainees, policy makers and former personnel working at Guantánamo; and (3) a database of over 1,000 newspaper articles regarding former detainees. It presents a factual record of the long-term impact of U.S. detention practices on detainees during their confinement at Guantánamo Bay and after their release. The study identifies problems with family reunification, reestablishing livelihood and changes in social status, and describes the meaning detainees ascribe to incarceration and the impact of incarceration on their views about their religion, identity, and relationship to their government. It also points to recommendations on appropriate legal mechanisms, detention practices, and policies to protect the human rights of detainees taken into U.S. custody in the "war on terror."

Ethical Issues Concerning the Role of Psychologists in the Interrogation of Detained Prisoners
Psychologists´ participation in the interrogation of detainees raises significant ethical issues. In official policy statements, the American Psychological Association (APA) has approved the participation of psychologists in interrogations at settings such as Guantánamo Bay and CIA "black sites," and their involvement in "Behavioral Science Consultation Teams" has been documented. Since 2005, the APA has developed progressively stronger condemnations of torture and has banned psychologists from engaging in specific interrogation techniques. Nevertheless, the APA has not swayed from its initial support of psychologists´ participation in activities that the International Committee of the Red Cross has described as "tantamount to torture." International agreements and the APA's own code of ethics may prohibit this involvement. The ethical conflict between some psychologists providing mental health treatment to detainees and other psychologists using their professional tools in the same settings to contribute to abusive interrogations has yet to be resolved. What are the ethical implications of health care professionals acting as "safety monitors" and attempting to gauge when interrogation conditions are likely to lead to trauma? This presentation also examines ways that health professionals may facilitate trauma prevention through research and public policy on detainee treatment.

Participant Alert: Although presenters are asked to avoid graphic descriptions, some content will relate to the abusive treatment of detained prisoners.

Current Age and Assessment Issues for Different Types of Trauma in Children and Adolescents

(Abstract #196101)

Symposium/Panel (Child, Asses Dx) **State Ballroom, 4th Floor**

Nader, Kathleen, DSW[1]; **Cohen, Judith, MD**[2]; **Levendosky, Alytia, PhD**[3]; **Fletcher, Kenneth, PhD**[4]

[1]*Director, Two Suns, for the Assistance of Traumatized Children and Adolescents, Cedar Park, Texas, USA*
[2]*Medical Director, Allegheny General Hospital, Pittsburgh, Pennsylvania, USA*
[3]*Department of Psychology, Michigan State University, East Lansing, Michigan, USA*
[4]*Department of Psychiatry, University of Massachusetts Medical School (Worcester), Worcester, Massachusetts, USA*

Clinician-researchers will review findings regarding differences in youth trauma presentation 1) among three youth age groups (under 8, 8-13, 14-17), 2) from adult trauma, and 3) related to the type of trauma a youth endures. Data and a new complex trauma scale for children will be presented.

An Introduction to the Differences in Youth and Adult Trauma and a Review of Findings for Adolescents
Nader, K.

In recent years, researchers have discussed a number of difficulties related to applying adult PTSD criteria to children and adolescents. In addition to differences in trauma´s manifestation among age groups, traumatic experiences can derail a youth´s normal life trajectory by causing developmental disruptions (e.g., brain and age appropriate social, academic, and personal skill development), undermining of resilience factors, and altered information processing and patterns of interaction. Factors that are relevant to a youth´s reactions vary across age groups (e.g., toddlers, children, early adolescents, and late adolescents). Even though older adolescents´ traumatic reactions may be similar to those of adults, youths can have a decidedly different presentation and reporting style (Nader, 2008). A review of clinical and research findings related to adolescent trauma (ages 14-17) will be presented.

Assessment of Trauma in School Aged Children
Cohen, J. & Mannarino, A.P.

Purpose: Recent studies indicate that more than 60% of school-aged children experience potentially traumatic events (PTE) and of these about a quarter have significant symptoms of Posttraumatic Stress Disorder (PTSD), often unrecognized and untreated. This presentation will describe alternative ways of assessing PTSD in children ages 8-13 years old.

Methods: 197 children in 3 New Orleans schools were assessed in group settings at schools using the Child PTSD Symptom Checklist (CPSS). Teachers reported on children´s internalized symptoms. A small number (20) of these children also received individual semi-structured interviews using the KSADS-PL.

Findings: Of the 197 children, 125 (63%) self-reported having significant PTSD symptoms. According to teacher report, only 10% of children met criteria for having significant internalizing symptoms. Of the 20 children receiving KSADS-PL, all had significant anxiety symptoms, but 6 (30%) did not report PTE. These children had a predominance of hyperarousal symptoms on the CPSS and were considered false positives for PTSD.

Conclusions: Significant numbers of children exposed to PTSD develop PTSD symptoms, and school-based assessment provides an important opportunity for identifying these children. Tips for optimizing school-based assessments are discussed during this presentation.

Current Findings on PTSD for Children Under 8: Domestic Violence as a Case Example
Levendosky, A. & Bogat, G. A.

Young children pose particular difficulties in assessment of trauma symptoms. First, parental report is required for very young children. Second, young children may exhibit different trauma symptoms than older children and adults, including development of new fears and Posttraumatic play. Current *DSM-IV* criteria do not adequately address issues related to trauma symptomatology in young children. Third, young children appear to have a neurobiological difference in response to trauma. Adolescents and adults with PTSD generally show elevated levels of basal cortisol. In contrast, in young children, both lowered and elevated levels of basal cortisol are found. Finally, young children may respond differentially to different traumatic events. Our own longitudinal study of the effects of domestic violence (DV) on women and children´s functioning beginning during pregnancy will be discussed. We collected maternal report on mother´s and children´s PTSD and DV yearly, from ages 1 through 7. Half of the children exposed to DV at each time period developed some trauma symptoms. Maternal and child PTSD symptoms were correlated for the children ages 1-3, suggesting that young children may be particularly vulnerable to relational PTSD due to their close physical and emotional relationship with their parents.

A Measure to Assess Children's Reactions to Chronic Interpersonal Stressors
Fletcher, K.

Each year millions of children are victims of interpersonal violence: physically, sexually, or emotionally abused, witness to parental violence, victims of community violence, and so on. Many of the children involved with state departments of social services or the juvenile justice system have histories of extended and varied interpersonal violence. The consequences of such chronic stressors in a child´s life go far beyond simple PTSD. Questions are now being raised about the utility and importance of diagnosing the more extreme and long-lasting reactions of children to such chronic, interpersonal trauma with a new diagnostic category of Complex PTSD or Developmental Trauma Disorder. In order to better identify and treat the symptoms of children with such histories of interpersonal violence, a new measure of Complex PTSD in Children has been developed that assesses symptoms of difficult problems of attachment insecurity, under- and poorly developed systems of affect and self-regulation, damaged self-esteem, and a potential for substance abuse, painful somatic problems that are resistant to treatment, increased depression, dissociative experiences, and a variety of other difficult behavioral and emotional problems associated with this disorder. The challenges to developing this measure and its rationale will be discussed.

Applying Mindfulness-Based Interventions for Trauma Across Diverse Populations

(Abstract #196206)

Symposium/Panel (Clin Res, Cul Div) **Monroe Ballroom, 6th Floor**

La Bash, Heidi, BS[1]; *Follette, Victoria, PhD*[1]; Dutton, Mary Ann, PhD[2]; Niles, Barbara, PhD[3]; Ryngala, Donna, PhD[3]; Klunk-Gillis, Julie, PhD[3]; Paysnick, Amy, BA[3]; Silberbogen, Amy, PhD[3]; Elbert, Thomas, PhD[4]; Schauer, Elisabeth, MPH, MA[5]; Catani, Claudia, PhD[5]; Kohila, M., PhD[6]; Somasundaram, D., PhD[7]; Ruf, Martina, PhD[4]; Schauer, Maggie, PhD[4]; Neuner, Frank, PhD[8]; Ford, Julian, PhD[9]; Steinberg, Karen, PhD[9]; Moffitt, Kathie, PhD[9]; Zhang, Wanli, PhD[9]
[1]*University of Nevada Reno, Reno, Nevada, USA*
[2]*Georgetown University, Washington, District of Columbia, USA*
[3]*National Center for PTSD, Jamaica Plain, Massachusetts, USA*
[4]*University of Konstanz, Konstanz, Germany*
[5]*vivo international, Ancona, Italy*
[6]*Vallikamam Educational Zonal Office, Vallikamam, Sri Lanka*
[7]*University of Jaffna, Jaffna, Sri Lanka*
[8]*Centre for Psychiatry, Reichenau, Reichenau, Germany*
[9]*Univ of Conn Health Ctr Dept of Psych, Farmington, Connecticut, USA*

Mindfulness, originally a construct used in Eastern spiritual and philosophical traditions, has found new utility in the treatment of Posttraumatic Stress Disorder. This symposium presents the results of mindfulness-based treatment packages evaluated in diverse populations, including US combat veterans, Sri Lankan school children, and low-income women of color.

Mindfulness-Based Trauma Interventions for Intimate Partner Violence
Mindfulness is described as “bringing one's complete attention to the present experience on a moment-to-moment basis” (Marlatt & Kristeller, 1999, p. 68). Mindfulness interventions have been developed to address an array of physical and mental health problems. However, none specifically address the needs of trauma populations. The goal of our mindfulness-based trauma intervention is to address the mental health care disparity for low-income, minority women exposed to intimate partner violence. Pilot data from a 3-day wellness retreat with ethnically-diverse battered women´s shelter workers (n = 65) showed that although few women had previous experience with meditation practices (55.4%), among those who returned to the second retreat (n = 27), 58.3% reported engaging in at least one type of mindfulness practice (e.g., sitting, walking, eating, yoga) at least once a week over the 6-month period of the program. These data suggest the acceptability of mindfulness practice among an ethnic and cultural minority population. The focus of this discussion is on 1) safety issues, 2) adaptations of mindfulness interventions for this population, 3) acceptability of the intervention, 4) the role of self-management and 5) preliminary data from a comparison of battered women participating in mindfulness vs. psycho-education groups in a shelter setting.

Evaluation of a Mindfulness Telehealth Intervention for Veterans With PTSD
Ongoing military conflicts have spurred interest in innovative treatments for veterans with PTSD. Despite recent speculation that mindfulness meditation may be an effective component of treatment for Posttraumatic Stress Disorder, there are few empirical studies evaluating its feasibility and efficacy. Mindfulness treatments have been shown to ameliorate psychological symptoms that are common in veterans with PTSD: substance abuse, depression, hostility, and anxiety. Mindfulness Based Stress Reduction (MBSR; Kabat-Zinn, 1990) may be effective at promoting healing in veterans by reducing symptoms of PTSD and co-morbid disorders. Difficulties accessing treatment and concerns about stigma associated with mental health treatment have been identified as important barriers preventing veterans

from seeking available treatment for PTSD and other disorders. Telephone interventions have shown promise as accessible, cost-effective ways to deliver or extend treatments for a variety of disorders. As part of an investigation that compares two telehealth treatments for PTSD, we developed an 8-week mindfulness intervention based on MBSR specifically for combat veterans. In this presentation we will describe the intervention, and present preliminary findings about feasibility in this population, compliance with homework, and efficacy in ameliorating symptoms.

Treatment of Psychological Trauma in Children After War in North-Eastern Sri Lanka: A Randomised Controlled Trial Comparing NET vs. Mindfulness Meditation/Relaxation
Sri Lanka's civil war has now lasted more than two decades and has deeply impacted the local population; a quarter of the children in the war torn areas suffer from PTSD. A randomised controlled treatment trial in Jaffna and Vallikamam was conducted to test the feasibility of implementing a large-scale evidence-based mental health service in resource-poor setting. Trained local teachers interviewed 469 children aged 11-15 years under supervision. The most severely affected children (N= 48) were randomized to receive six sessions of either KIDNET (Narrative Exposure Therapy for Children) or a Mindfulness Meditation-Relaxation Protocol. PTSD remitted in all but one of the children in the KIDNET group and in two-thirds of the children in the Meditation group who were not exposed to additional traumatic stressors. Depression symptoms were also markedly at the 6-months post-tests and a 14-months follow-up. This study shows that large-scale evidence-based mental health service structures can be successfully implemented and utilized. It further shows that locally trained lay personnel can effectively apply trauma-focused exposure therapy techniques. The outcome suggests that a combination of meditation in groups and followed when necessary by individual NET-treatment might be an efficient way to assist survivors to regain mental well-being in the aftermath of large-scale disasters.

The Role of Mindfulness in a Randomized Clinical Trial of Affect Regulation and Social Problem Solving Psychotherapies for Low Income Mothers With PTSD
This study assesed the efficacy and trajectory of change in two therapies for PTSD with low-income, predominantly ethnoracial minority, young mothers. Trauma Affect Regulation: Guide for Education and Therapy (TARGET; Ford & Russo, 2006) and Present Centered Therapy (PCT; McDonagh-Coyle et al., 2005) were associated with significant improvements at post-test and 3-month and 6-month follow-up assessments, with TARGET associated with greater improvement in PTSD symptoms and affect regulation. Analyses showing differential patterns of within-treatment predictors of change are reported, which suggest that reductions in psychometric scores for PTSD, anxiety, depression and dissociation and improved affect regulation following treatment were predicted by: (a) lower initial negative affect, higher initial and session 4 positive affect, and reduced anxiety about PTSD at session 4 in PCT, but (b) by reduced anxiety about both trauma memories and PTSD and lower levels of both positive and negative affect at session 4 in TARGET. Session 10 predictors of positive outcomes included lower anxiety about trauma memories and higher hope in both treatments, but higher positive affect in PCT and lower anxiety about PTSD symptoms in TARGET. Results are interpreted as suggesting different change trajectories that may reflect remoralization in PCT and increased mindfulness in TARGET.

Risk and Resilience Following Mass Trauma: The Virginia Tech Campus Shootings

(Abstract #196471)

Symposium/Panel (Disaster, Sos Ethic) **Salons 7-9, 3rd Floor**

Littleton, Heather, PhD[1]; Bye, Kimberly, BA[1]; Axsom, Danny, PhD[2]; *Ullman, Sarah, PhD[5]*, Langelier, Adrienne, BS[3]; Grills-Taquechel, Amie, PhD[4]
[1]Psychology, Sam Houston State University, Huntsville, Texas, USA
[2]Virginia Polytechnic Institute and State University, Blacksburg, Virginia, USA
[3]Psychology, Sam Houston State University, Huntsville, Mississippi, USA
[4]Psychology, University of Houston, Houston, Texas, USA
[4]Criminal Justice Department, University of Illinois at Chicago, Chicago, Illinois, USA

The worst mass shooting in U.S. history occurred at Virginia Tech. Panelists will present findings from a prospective study of adjustment following the shootings. Findings support pre-trauma distress and prior trauma as risk factors and social support as a resiliency-promoting factor. Findings also examine the role of post-trauma experiences.

Examining Post-Shooting Distress From a Conservation of Resources Framework
Using a conservation of resources framework, predictors of adjustment two and six months after the shooting incident at Virginia Tech were evaluated. It was hypothesized that resource loss and reliance on avoidant and ruminative strategies in coping with the shooting would predict distress following the shooting. Further, it was hypothesized that pre-shooting distress and social support would predict both resource loss following the shooting and reliance on maladaptive coping strategies. 293 Virginia Tech women on whom data were collected with regard to their pre-trauma distress and social support completed an online survey about their adjustment, coping, and resource loss following the shooting. A total of 193 of these women completed a similar survey six months after the shooting. Results of structural equation models were consistent with hypotheses. Resource loss and maladaptive coping predicted distress two months after the shooting incident. Both resource loss and maladaptive coping were predicted by pre-trauma distress and social support. With regard to adjustment six months after the shooting, reported resource loss and maladaptive coping at two months emerged as significant predictors. Implications of the findings for identifying at-risk and resilient individuals following mass trauma are discussed.

Cumulative Effects of Multiple Traumas on Quality of Life: Benevolence Beliefs as a Potential Mediator
Past research has suggested that the effects of trauma may be cumulative. In particular, the deleterious impact of multiple traumas on culturally valued beliefs (e.g., belief in one´s worth, beliefs about the benevolence of the world and others) has been described. to examine this possibility, data collected from multiple trauma victims (i.e., victims exposed to sexual trauma prior to the shooting and the Virginia Tech shooting) and single trauma victims (i.e., victims exposed to the shooting) were compared, in a sample of VT women who completed a survey prior to, and two months following, the shooting. It was hypothesized that, compared to single trauma victims, multiple trauma victims would report a lower quality of life following the shooting and less belief in benevolence, and that benevolence would act as a significant mediator. Results were consistent with hypotheses; multiple trauma victims reported lower quality of life in several domains (psychological, physical, and environmental) and less benevolence beliefs. Mediation analyses were then conducted following the three step procedure recommended by Baron and Kenny. Results supported the meditational role of benevolence beliefs with regards to all three quality of life constructs. Sobel tests indicated that the mediation was significant.

Social Support Following the Virginia Tech Shootings
Social support plays an important role in understanding reactions to traumatic events.

Mass traumas, compared to events such as rape, are unique in several respects relevant to social support; they affect many people simultaneously, are public in nature, and are often less stigmatizing to individuals affected. We examine changes in functional social support (assessed by the MSPSS) following the Virginia Tech shootings in a sample of female undergraduates from whom pre-event data had been collected for an unrelated study. Follow-ups 2 and 6 months post-shooting indicated a general increase in social support from baseline. There was also an interaction between time and support type (family vs friend), indicating that the increase primarily reflected a rise in family support, which, relative to friend support, was less strong prior to the shootings. Regression analyses controlling for pre-shooting social support indicated such factors as a belief in the benevolence of people and pre-shooting depression predicted social support 6 months post-event. These patterns were evident for friend but not family support, perhaps reflecting a difference in self vs other-initiated support. Findings are discussed in terms of the social ecology of campus shootings, with implications for theories of trauma-related social support and for post-trauma interventions.

Papers
Biological Issues in Veterans

Adams Ballroom, 6th Floor

Chair: Roger Pitman, MD, Psychiatry,
Massachusetts General Hospital/Harvard Medical School, Charlestown, Massachusetts, USA

Headaches in Veterans Returning From Iraq/Afghanistan: Relation to Trauma and Combat-Related Injury

(Abstract #196463)

Paper Presentation (Mil Emer, Clin Res)

Afari, Niloofar, PhD[1]; Harder, Laura H., BA[2]; Heppner, Pia S., PhD[3]; Madra, Naju J., MA[2]; Orcutt, Jodi L., PsyD[2]; Baker, Dewleen G., MD[3]
[1]Department of Psychology, Veterans Affairs San Diego Healthcare System/University of California San Diego, San Diego, California, USA
[2]Psychiatry Research Service, Veterans Affairs San Diego Healthcare System, San Diego, California, USA
[3]Department of Psychiatry, Veterans Affairs San Diego Healthcare System/University of California San Diego, San Diego, California, USA

Limited research has shown that stress and headaches may be similar in physiological mechanism. Additionally, psychological stress may mediate the onset and progression of a headache disorder. The present study investigated the relationship between Posttraumatic Stress Disorder (PTSD) and headaches in 343 newly registered Operation Iraqi Freedom (OIF) and/or Operation Enduring Freedom (OEF) veterans at the VA San Diego Healthcare System. Veterans completed a battery of standardized self-report questionnaires between March and October 2006. Data consisted of demographic, military, in-theater, psychiatric, and health-related variables. Results from logistic regression analysis indicated that PTSD and injury during combat were independent predictors of self-reported headaches. Individuals who endorsed PTSD were 4 times (95% confidence interval: 2.15-8.01; $p < 0.001$) more likely to report headaches than veterans without PTSD. Individuals injured during combat were nearly 3 times (95% confidence interval: 1.38-5.62; $p = 0.004$) more likely to report headaches compared to veterans who did not report injury during combat. Follow-up analyses demonstrated that PTSD and injury during combat could be differentially related to tension and migraine headaches. These findings have implications for a comprehensive approach to interventions with trauma exposed individuals.

Thinner Prefrontal Cortex in Veterans With Posttraumatic Stress Disorder

(Abstract #196215)

Paper Presentation (Bio Med, Res Meth)

Geuze, Elbert, PhD[1]; Westenberg, Herman, PhD[2]; De Kloet, Carien, MD, PhD[3]; Heinecke, Armin, MSC[4]; Goebel, Rainer, PhD[4]; Vermetten, Eric, MD, PhD[5]
[1]Research Centre, Military Mental Health Ministry of Defense, Utrecht, Netherlands
[2]Psychiatry, University Medical Center Utrecht, Utrecht, Netherlands
[3]Altrecht, Utrecht, Netherlands
[4]University of Maastricht, Maastricht, Netherlands
[5]University of Utrecht, Utrecht, Netherlands

Structural neuroimaging studies in posttraumatic stress disorder (PTSD) have focused primarily on structural alterations in the medial temporal lobe, and only a few have examined gray matter reductions in the cortex. Recent advances in computational analysis provide new opportunities to use semi-automatic techniques to determine cortical thickness, but these techniques have not yet been applied in PTSD. Twenty-five male veterans with PTSD and twenty-five male veterans without PTSD matched for age, year and region of deployment were recruited. All the subjects were scanned using MRI. Individual cortical thickness maps were calculated from the MR images. Regions of interest examined included the bilateral superior frontal gyri, bilateral middle frontal gyri, bilateral inferior frontal gyri, bilateral superior temporal gyri, and bilateral middle temporal gyri. Individual cortical thickness maps were calculated from the MR images. Veterans with PTSD revealed reduced cortical thickness in the bilateral superior and middle frontal gyri, the left inferior frontal gyrus, and the left superior temporal gyrus. Cortical thinning in these regions may thus correspond to functional abnormalities observed in patients with PTSD.

Resting Brain Metabolic Activity in Identical Twins Discordant for Combat Exposure

(Abstract #196286)

Paper Presentation (Bio Med, Res Meth)

Shin, Lisa, PhD[1]; Mohammed, Milad, PhD[2]; Lasko, Natasha, PhD[3]; Fischman, Alan, MD[4]; Rauch, Scott, MD[5]; Pitman, Roger, MD[2]
[1]Psychology, Tufts University, Medford, Massachusetts, USA
[2]Psychiatry, Massachusetts General Hospital/Harvard Medical School, Charlestown, Massachusetts, USA
[3]Research, VA Medical Center, Manchester, New Hampshire, USA
[4]Radiology, Massachusetts General Hospital/Harvard Medical School, Boston, Massachusetts, USA
[5]Psychiatry, McLean Hospital/Harvard Medical School, Belmont, Massachusetts, USA

Whether functional neuroimaging abnormalities in Posttraumatic stress disorder (PTSD) are acquired characteristics or pre-existing vulnerability factors is largely unknown. We used positron emission tomography and &lsqb18F&rsqb-fluorodeoxyglucose (FDG) to examine resting regional cerebral metabolic rates for glucose (rCMRglu) in combat-exposed veterans with PTSD and their identical, combat-unexposed co-twins, as well as in combat-exposed veterans without PTSD (n=19) and their co-twins. PTSD veterans and their co-twins had significantly higher resting rCMRglu in dorsal anterior/mid cingulate cortex (dA/midCC) than non-PTSD veterans and their co-twins. Resting dA/midCC rCMRglu in unexposed co-twins predicted alcoholism in themselves, as well as severity of combat exposure and PTSD adjusted for severity of combat exposure in their exposed twins. Previous work has found that common additive genetic influences predict alcoholism, exposure to military combat, and PTSD upon such exposure. Enhanced resting metabolic activity in this region may represent an endophenotypic manifestation of these genetic influences.

Global and Regional Cortical Volumes in Combat-Related Posttraumatic Stress Disorder

(Abstract #196473)

Paper Presentation (Bio Med, Asses Dx)

Woodward, Steve, PhD[1]
[1]*Department of Veterans Affairs, Palo Alto, California, USA*

Introduction: Global brain volume appears to be smaller in adolescents with posttraumatic stress disorder (PTSD). Brain volume is moderately correlated with intelligence, and lower intelligence, in turn, is a risk factor for PTSD. Hence, it is surprising that only one study has observed smaller brain volume in adults with PTSD.

Methods: Subjects were 97 adult combat-related PTSD patients and combat-exposed controls. Tissue-weighted MR images collected at 1.5T were analyzed with FreeSurfer (v4.0.1) in order to extract the 2-D cortical sheet and compute its thickness. The cortical model was 'gyrographic' parcellated and volumes calculated.

Results: Cortical volume was smaller in adult combat-related PTSD. Robust associations were observed between PTSD and smaller cortical volumes in parahippocampal, superior temporal, lateral orbital frontal cortex, and inferior frontal cortex.

Discussion: Cortical volume was smaller in adult PTSD than in combat controls. The four regions that exhibited especially smaller cortical volumes share – along with hippocampus - involvement in mechanisms subserving "top-down" facilitation of object and word identification. Compromise of these regions suggests PTSD is characterized by impaired plasticity of these "top-down" functions, and may explain the difficulty PTSD patients have in reacquiring civilian function.

Papers

Treatment Issues in Combat-Related Stress

Salon 1, 3rd Floor

Chair: Shay Lee Belik, BSc (HONS),
Psychiatry and Community Health Sciences, University of Manitoba, Winnipeg, Manitoba, Canada

Acupuncture for Posttraumatic Stress Disorder: A Randomized Trial in a Military Population

(Abstract #196398)

Paper Presentation (Clin Res, Mil Emer)

Engel, Charles C., MD, MPH[1]**; Harper Cordova, Elizabeth, MA**[2]**; Benedek, David, MD**[3]**; Jonas, Wayne, MD**[4]**; Ursano, Robert, MD**[3]
[1]*Department of Psychiatry, Uniformed Services University of the Health Sciences, Deployment Health Clinical Center, Walter Reed Army Medical Center, Washington, District of Columbia, USA*
[2]*Deployment Health Clinical Center, Walter Reed Army Medical Center, Washington, District of Columbia, USA*
[3]*Department of Psychiatry, Uniformed Services University of the Health Sciences, Bethesda, Maryland, USA*
[4]*Samueli Institute for Information Biology, Alexandria, Virginia, USA*

10-17% of soldiers returning from the Iraq War experience PTSD in the year following deployment. Stigma and lack of confidence in existing treatments often prevents soldiers from seeking care. We sought to assess the efficacy of acupuncture for PTSD among military personnel. Four weeks of twice weekly manualized Chinese medicine acupuncture were administered. Soldiers diagnosed with PTSD (CAPS) were randomized to acupuncture (ACU) or usual care (UC) with 12 weeks of follow-up. Primary outcome was PTSD symptom severity (PCL). Secondary outcomes were depression (BDI) and functioning (SF-36). 42 of 55 (76%) randomized soldiers provided complete follow-up data. Compared to UC, ACU was associated with a significantly greater decrease in PTSD symptoms, which was maintained through the 12-week follow-up (treatment X time, $F(3, 128) = 10.92$, $p < .001$); mean PCL decreases were 19.4 (±11.7) at end treatment and 19.8 (±13.6) at 12-week follow-up in ACU vs. 4.0 (±12.3) at end treatment and 9.7 (±13.1) at 12-week follow-up in UC. Similar patterns of improvement were seen with symptoms of depression and psychological functioning. Brief acupuncture offers short-term benefit over usual care for military personnel with PTSD. Future studies should evaluate longer follow-up and acupuncture components.

Pilot Study of a Mindfulness-Based Cognitive Therapy for Combat Veterans Seeking Treatment for PTSD

(Abstract #195972)

Paper Presentation (Mil Emer, Clin Res)

King, Anthony, PhD[1]**; Giardino, Nicholas, PhD**[2]**; Erickson, Thane, PhD**[1]**; Kulkarni, Madhur, MS**[3]**; Perkins, Suzanne, PhD**[1]**; Liberzon, Israel, MD**[1]
[1]*Psychiatry, University of Michigan, Ann Arbor, Michigan, USA*
[2]*Psychiatry, University of Michigan/ VAAAHCS, Ann Arbor, Michigan, USA*
[3]*Psychology, University of Michigan, Ann Arbor, Michigan, USA*

We are studying the feasibility, acceptability, and efficacy of Mindfulness-based Cognitive Therapy adapted for combat veterans seeking treatment at a VA outpatient PTSD clinic. 21 consecutive veterans were recruited, n=15 into MBCT groups, n=6 to a comparison group (PTSD psycho-ed). MBCT involved 8 weekly group sessions of mindfulness exercises with PTSD-specific content for managing intrusive thoughts and feelings, and daily home practice with audio CDs. We collected pre- and post therapy psychiatric assessments, circadian cortisol & response to awakening, and attentional control (ANT). Four patients dropped MBCT; but completers showed strong compliance in home practice. MBCT showed significant improvement in the Clinician Administered PTSD Scale ($p<.05$) explained by "avoidant" symptoms (reduced from 32 to 18, $p<.005$, Hedges $g=1.09$ compared to control). Improvements ($p<.05$) were also seen in self-report PTSD symptoms, and self-blame cognitions (Posttraumatic Cognitions Inventory). These data suggest MBCT appears clinically acceptable to veterans seeking treatment for PTSD, and potentially beneficial, and may have relatively specific effects on symptoms (i.e. avoidant) and cognitions (guilt), which may make it a useful adjunct. Analyses of psychophysiological, cognitive/attentional, and HPA axis measures are ongoing, and an fMRI neuroimaging study is underway.

Relationship Between Traumatic Events and Suicide Attempts in Canadian Military Personnel

(Abstract #196418)

Paper Presentation (Mil Emer, Clin Res)

Belik, Shay-Lee, BSC (HONS)[1]**; Stein, Murray, MD**[2]**; Asmundson, Gordon, PhD**[3]**; Sareen, Jitender, MD**[4]
[1]*Psychiatry and Community Health Sciences, University of Manitoba, Winnipeg, Manitoba, Canada*
[2]*University of California, San Diego, La Jolla, California, USA*
[3]*University of Regina, Regina, Saskatchewan, Canada*
[4]*Psychiatry, University of Manitoba, Winnipeg, Manitoba, Canada*

The aim of the current study was to determine whether exposure to particular types of traumatic events was differentially associated with suicide attempts in a representative sample of active military personnel. Data came from the Canadian Community Health Survey Cycle 1.2 Canadian Forces Supplement (N=8,441; response rate 81.1%). Respondents were asked about exposure to 28 traumatic events that occurred during their lifetime. The prevalence of lifetime suicide attempts for currently active Canadian military men and women was 2.2% and 5.6%,

respectively. Sexual and other interpersonal traumas (e.g., rape, sexual assault, child abuse) were significantly associated with suicide attempts in men, even after adjusting for sociodemographics and mental disorders. in women, sexual and other interpersonal traumas also demonstrated the strongest association with suicide attempts; however, the majority of these relationships appeared to be accounted for by development of a mental disorder. Additionally, the number of traumatic events experienced was positively associated with increased risk of suicide attempts, indicating a dose-response effect of exposure to trauma. The current study is the first to demonstrate that sexual and other interpersonal traumatic events are associated with suicide attempts in a representative sample of active Canadian military men and women.

Posttraumatic Stress Disorder and Health Related Quality of Life in Canadian Peacekeeping Veterans

(Abstract #195879)

Paper Presentation (Mil Emer, Asses Dx)

Richardson, Don, MD, FRCPC[1]

[1]*Operational Stress Injury Clinic-Parkwood Hospital, University of Western Ontario, London, Ontario, Canada*

Objectives: to examine the health-related quality of life (HRQol) in deployed Canadian Forces peacekeeping veterans, addressing associations with posttraumatic stress disorder (PTSD) and depression severity.

Methods: Participants were 125 consecutive male veterans who were referred for a psychiatric assessment. Instruments administered included the Clinician-Administered PTSD Scale (CAPS), Hamilton Depression Scale, Short-Form-36 Health Survey (SF-36) and sociodemographic characteristics.

Results: Mental HRQol was significantly lower for peacekeepers with than without PTSD. Using univariate analyses, PTSD and depression severity were each significantly negatively related to mental HRQol. In sequential regression analyses controlling for age, we found that PTSD and depression severity significantly predicted both mental and physical HRQol. Conclusions: Veterans with PTSD have significant impairments in mental and physical HRQoL. This information is useful for clinicians and VA administrators working with the newer generation of veterans as it stresses the importance of including measures of quality of life in the psychiatric evaluation of veterans in order to better address their rehabilitation needs.

Papers
Basic Research in PTSD

Salon 3, 3rd Floor

Rajendra Morey, MD, Psychiatry,
Duke University, Durham, North Carolina, USA

Effects of Repeated Stress on Cannabinoid Receptor Type 1 mRNA Expression in Rat Brain

(Abstract #196456)

Paper Presentation (Bio Med, Res Meth)

Carlton, Janis, MD, PhD[1]**; Xing, Guoqiang, PhD**[2]**; Zhang, Lei, MD**[2]**; Li, He, MD, PhD**[3]**; Ursano, Robert, MD**[4]

[1]*Psychiatry, Uniformed Services University of the Health Sciences, Bethesda, Maryland, USA*
[2]*Department of Psychiatry, Uniformed Services University of the Health Science, Bethesda, Maryland, USA*
[3]*Uniformed Services University of Health Sciences, Bethesda, Maryland, USA*
[4]*Psychiatry, Uniformed Services University of Health Sciences, Kensington, Maryland, USA*

Purpose: The endogenous cannabinoid system is involved in emotion, memory, cognition, and pain perception by activation of the presynaptic cannabinoid receptor type 1 (CBR1) that is highly expressed in several brain regions and serves to inhibit release of neurotransmitters including GABA, glutamate, acetylcholine, and monoamines.

Methods: Adult male Sragues-Dawley rats were exposed to repeated immobilization and tail-shock stress. Brain region specific mRNA were determined by quantitaive real-time polymer chain reaction.

Findings: There was a marked increase in CBR1 mRNA in the brain stem and cingulate cortex of stressed rats but not in other regions examined.

Conclusions: These results indicate a role of CBR1 receptors in stress-induced alterations in brain neurotransmission and behavioral change. We are currently working to replicate and extend these findings with ongoing studies involving the cerebellar cannabinoid receptors which may mediate altered time sense, spatial memory and fear extinction, critical features of per-traaumatic dissociation, acute stress reactions, and initiation of Posttramatic Stresss Disorder (PTSD). Implications for understanding PTSD related phenomena including cognitive changes and increased risk of substance abuse will also be discussed.

Stress-Induced Regional and Sex Differences in Adrenergic Receptor mNRA in Rat Brain

(Abstract #196469)

Paper Presentation (Bio Med, Res Meth)

Xing, Guoqiang, PhD[1]**; Carlton, Janis, MD, PhD**[2]**; Fullerton, Carol, PhD**[1]**; Zhang, Lei, MD**[1]**; Li, He, MD, PhD**[3]**; Ursano, Robert, MD**[1]

[1]*Psychiatry, Uniformed Services University of Health Sciences, Bethesda, Maryland, USA*
[2]*Psychiatry, Uniformed Services University of the Health Sciences, Bethesda, Maryland, USA*
[3]*Uniformed Services University of Health Sciences, Bethesda, Maryland, USA*

Purpose: Dyregulation of adrenergic pathways is thought to be critical in the etiology of PTSD. The role of adrenergic receptor subtypes is unknown. We hypothesized that receptor subtypes could play a distinct role in stress-induced changes related to PTSD.

Methods: Adult rats were exposed to repeated stress. mRNA was extracted from amygdala, hippocampus, hypothalamus and prefrontal cortex. The mRNA expression for receptor subtypes alpha-1A, 1B, 1C, 2A, 2B, 2C, and beta-1, 2 and 3 were determined by qPCR.

Findings: Stressed male rats showed a decrease in alpha 1A and beta-1 mRNA in all brain regions and an increase in alpha 1B, 1C, 2A, 2B, and 2C in hypothalamus, amygdala and prefrontal cortex. Beta 3 mRNA was increased in hypothalamus but decreased in hippocampus. Stressed female rats had increased alpha 1B, 1C, 2B, 2C, and beta 2 in hypothalamus and prefrontal cortex and decreased alpha 1A, 2A, and beta 1 mRNA in amygdala. Beta 3 mRNA was increased in prefrontal cortex and decreased in hippocampus.

Conclusions: Our data show a complex pattern of adrenergic receptor mRNA induction after repeated stress. The data support important roles of adrenergic receptor subtypes in stress-induced changes in brain through divergent changes in expression patterns in different brain regions in both males and females. Behavioral correlates will be discussed.

Serotonin Transporter Gene Modulates Neural Systems for Working Memory in PTSD

(Abstract #196489)

Paper Presentation (Bio Med, Asses Dx)

Morey, Rajendra, MD[1]; McCarthy, Gregory, PhD[2]; Munger, Heidi, BS[3]; Rimmler, Jacqueline, MS[3]; Seth, Srishti, BA[3]; Schmidt, Silke, PhD[3]

[1]Psychiatry, Duke University, Durham, North Carolina, USA
[2]Yale University, New Haven, Connecticut, USA
[3]Duke University, Durham, North Carolina, USA

Purpose: Variants of the serotonin transporter gene have been shown to influence amygdala activation in response to emotional faces and also expression of PTSD. We examined the role of the serotonin transporter gene on activation of brain regions implicated in PTSD.

Methods: We used functional MRI to examine neural activity in a PTSD group (n=21) and a trauma-exposed control group (n=21) who were asked to maintain information in working memory while simultaneously distracted by trauma-related material not relevant to the ongoing task. We assayed two polymorphisms of the serotonin transporter gene (i) SNP 16965628 (CG, GG) and (ii) 5HTTLPR-RS25531 (high, low, reference serotonin expression).

Findings: Activation levels in regions of interest were derived by contrasting the most and least distracting conditions in all participants. Emotion processing and working memory brain activity was differentially modulated by the serotonin transporter gene in the PTSD group. Variants of RS16965628 modulated the ventrolateral PFC [F(3,38)=7.7, P<.0005] and the dorsolateral PFC [F(3,38)=2.8, P=.05]. Variants of 5HTTLPR-RS25531 modulated the ventrolateral PFC [F(5,36)=4.2, P<.005] and fusiform gyrus [F(5,36)=4.1, P<.005].

Conclusions: Functional MRI may identify dimensions of PTSD that are more closely related to susceptibility genes than current clinical categorizations.

Low BDNF and Childhood Physical Neglect Impacting Verbal Memory in Depression

(Abstract #195851)

Paper Presentation (Bio Med, Asses Dx)

Grassi-Oliveira, Rodrigo, MS, MD, PhD[1]; Stein, Lilian, PhD[1]; Lopes, Rodrigo, MS[2]; Teixeira, Antonio, MD, PhD[3]; Bauer, Moises, PhD[2]

[1]Psychology, Pontifical Catholic University of Rio Grande do Sul, Porto Alegre, RS, Brazil
[2]Molecular and Cellular Biology, Pontifical Catholic University of Rio Grande do Sul, Porto Alegre, RS, Brazil
[3]Internal Medicine, Federal University of Minas Gerais, Belo Horizonte, MG, Brazil

Animal models of repeated maternal separation have been shown reduced brain-derived neurotrophic factor (BDNF) levels in specific brain regions implicated with memory formation. The aim of this preliminary study was to investigate whether childhood physical neglect (CPN) and plasma BDNF levels would impact on memory performance in adults. Recurrent MDD females with CPN (MDD + CPN, n=17) and without CPN (MDD, n=17), and healthy controls (n = 15) were assessed for plasma BDNF and verbal memory performance. MDD patients showed low plasma BDNF concentrations than healthy controls ($p < 0.001$). MDD + CPN had even lower BDNF levels compared with controls and MDD ($p < 0.05$). BDNF levels were negatively related to psychological morbidity and positively correlated to memory performance. Regression models showed that severity of self-reported CPN and low plasma BDNF predicted impairment on immediate verbal recall. Delayed recall impairment was predicted by severity of CPN and depression, and memory retention by PTSD severity symptoms. Our data suggest that CPN and plasma BDNF are important factors associated with depression and verbal memory performance.

Teaching Trauma

(Abstract #195726)

Workshop/Case Presentation (Media Ed, Sos Ethic) **Salon 2, 3rd Floor**

Kimble, Matthew, PhD[1]; Flack, William, PhD, PHARMD[2]; Elhai, Jon, PhD[3]; Davis, Joanne, PhD[4]; Krause, Elizabeth, PhD[5]

[1]Psychology, Middlebury College, Middlebury, Vermont, USA
[2]Bucknell University, Lewisburgh, Pennsylvania, USA
[3]University of South Dakota, Vermillion, South Dakota, USA
[4]University of Tulsa, Tulsa, Oklahoma, USA
[5]Psychology, Univeresity of Pennsylvania, Philadelphia, Pennsylvania, USA

This workshop will focus on how to effectively teach the topic of trauma in the classroom. The workshop will be lead by five instructors who have all taught courses on "Psychological Trauma" either at the undergraduate level, graduate level, or both. Dr. Kimble will introduce the topic and discuss challenges that are specific to teaching a course on trauma. Dr. Krause will present on how to sensitively address gender, culture, and vulnerability in a course on traumatic stress. Dr. Elhai will discuss using the classroom as a springboard for debate and discussion of controversial and topical traumatic stress issues. Dr. Davis will discuss the use of film as a valuable teaching tool and Dr. Flack will discuss service-learning as a pedagogical strategy that highlights the complex realities of trauma, particularly in comparison to the simplified picture presented in scholarly research. Sample syllabi and associated class assignments will be made available at the workshop. Talks will be limited to 10 minutes to allow for ample discussion/interaction with the audience.

Utilization of EMDR With Traumatic Bereavement
(Abstract #195773)

Workshop/Case Presentation (Practice, Disaster) **Salons 4-6, 3rd Floor**

Solomon, Roger, PhD[1]; Rando, Therese A., PhD[2]
[1]Buffalo Center for Trauma and Loss, Buffalo, New York, USA
[2]The Institute for the Study and Treatment of Loss, Warwick, Rhode Island, USA

Traumatic bereavement is the state of having suffered the loss of a loved one when grief is overpowered by the traumatic stress brought about by its circumstances. Trauma can disable the ability to cope, impair functioning, and compromise the ability to adapt. Trauma also complicates the mourning by interfering with the processes the mourner has to go through for assimilation and accommodation of the loss.

Eye Movement Desensitization and Reprocessing (EMDR), an integrative psychotherapeutic approach, is an effective treatment for trauma. The underlying theoretical model (Adaptive Information Processing Model) posits that trauma can lead to experiences becoming "frozen" in the brain in state specific form, unable to process. EMDR processing involves the forging of new associations, with adaptive information from other memory networks able to link in to the memory network holding the dysfunctionally-stored information.

EMDR can be integrated into treatment of traumatic bereavement to process the trauma complicating the bereavement, and enable the mourner to complete the necessary processes involved in mourning the loss .

This presentation will discuss grief and bereavement, the processes the mourner has to go through for adaptive assimilation and accommodation of the loss, and how EMDR can be integrated into an overall treatment plan.

Immigrants and Domestic Violence (DV): Adjusting the Clinical Lens
(Abstract #195837)

Workshop/Case Presentation (Cul Div, Practice) **Wabash Room, 3rd Floor**

Woollett, Nataly, MA[1]
[1]Lutheran Family Health Centers, Brooklyn, New York, USA

As the immigrant population continues to grow in this country, there is an increased demand to understand the special needs of this group as they interface with mainstream mental health systems. Immigrants often experience trauma before, during and after immigration; traumatic events that professionals may overlook. These traumas frequently occur in early life and are compounded over time by psychosocial stressors leading to a more complex form of trauma. With regards to interpersonal trauma, immigrant women and children are particularly at risk to the terrifying experience of DV and are thus over represented in the mental health system dealing with DV. Psychoeducation will be provided on culturally competent assessment and clinical variables that affect treatment of immigrant families that deal with DV. Some clinical variables to discuss include the conflict that occurs between first and second-generation immigrants that reside in the same family, particular barriers undocumented immigrants face, low retention rates of immigrants in treatment etc. We will share the knowledge we have gained from working directly with immigrants who have informed us of the nuances of trauma and how it is experienced in individuals and families. Unaddressed needs of immigrant DV victims constitute a major public health concern.

Participant Alert: Some discussion topics related to domestic violence can be distressing to individuals.

Concurrent Session 10
Saturday, November 15
8:00 a.m. – 9:15 a.m.

The Biology of PTSD

Making Relevant Animal Models for PTSD: Looking for Phenotypic Variation, Rather Than Typical Response to Stress
(Abstract #198302)

Featured (Res Meth, Bio Med) **Grand Ballroom, 4th Floor**

Yehuda, Rachel, PhD[1]
[1]Mount Sinai School of Medicine Medical School, Bronx, New York, USA

The theoretical link between exposure to extreme stress and the development of PTSD provided the rationale for early hypotheses that PTSD-related biological alterations would be similar in direction to those observed acutely in animals exposed to stressors. When subsequent findings indicated that only a minority of trauma-exposed individuals develop PTSD an alternative hypothesis was generated proposing that PTSD involves a failure of mechanisms involved in recovery and restitution of physiological homeostasis, possibly resulting from individualistic predisposition. It has been challenging to interpret the extent to which biological alterations that are consistent with normative consequences of stress exposure in PTSD reflect pathogenesis.

This presentation will focus on attempts to develop animal models for PTSD based on the premise of examining individual differences to a uniform provocation that yields long-lasting biobehavioral consequences, analogous to those in PTSD. These strategies generally involve examination of biological underpinnings in phenotypic variation of differences in response to fear conditioning and other provocations and yield information addressing why only some persons exposed to trauma fail to recover.

Animal Models in PTSD: Their Contribution to Pharmacotherapy
(Abstract #198555)

Featured (Bio Med, Prev El) **Grand Ballroom, 4th Floor**

Zohar, Joseph, MD[1]; Cohen, Hagit, [2]
[1]Psychiatric Department, The Chaim Shiba Medical Center Israel, Herzlia, Israel
[2]Mental Health Center, Beer-Sheva, Israel

Although animal models of psychiatric disorders are limited to the assessment of measurable and observable behavioral parameters and cannot assess complex psychological symptoms such as thought, meaning and dreams, they are in some ways advantageous. Valid and reliable animal models may provide a means for researching biomolecular, pathophysiological and pharmacological features of the disorder in ways which are not feasible in human studies. PTSD provides a unique basis for an animal model, since in PTSD the trigger is well-known and universal – exposure to a traumatic event – and hence the center of gravity shifts from how to induce it to how to "diagnose" those animals who develop PTSD versus those who do not. The behavioral cut-off criteria were introduced, and based on this concept – setting apart the affected – we can isolate and study those animals who developed "PTSD-like behavior", comparing them to those who did not develop (although they were exposed) and to those who were not exposed.

Researchers who work with animals have long been aware that individual study subjects tend to display a varying range of responses to stimuli, certainly where stress paradigms are concerned. This heterogeneity in responses was accepted for many

years and regarded as unavoidable. Since humans clearly do not respond homogeneously to potentially traumatic experiences, the heterogeneity in animal responses might be regarded as confirming the validity of animal studies, rather than as a problem. It stands to reason that a model of diagnostic criteria for psychiatric disorders could be applied to animal responses to augment the validity of study data, as long as the criteria for classification are clearly defined, reliably reproducible and yield results which conform to findings in human subjects. Of course, different study paradigms may give rise to different sets of criteria.

This animal model enables us to test interventions that might be impossible (i.e. Anisomycin) or difficult (e.g. BNZ, SSRI, Cortisol) to do in a clinical setting without any proper preclinical basis. Results from interventions given at specific timepoints (either immediately after exposure or much later) in a group of rats that were followed prospectively will be presented. Their implications on potential pharmacological approaches will be discussed, with emphasis on three examples. One is early administration of SSRI, the second, early administration of cortisol and the long-term consequences. Thirdly, the early or late administration of cortisol in different dose regimens will be presented in the talk.

Treating Complex Trauma in Older Adolescents and Adults: The Self-Trauma Model

(Abstract #197587)

Master (Practice, Clin Res) **State Ballroom, 4th Floor**

Briere, John, PhD[1]
[1]*University of Southern California, Keck School of Medicine, Los Angeles, California, USA*

Recent research indicates that trauma-related disturbance can be quite complex. When trauma exposure involves early, repetitive, interpersonal maltreatment, or when there have been multiple and prolonged traumas in adulthood, the outcome may involve not only classic posttraumatic stress and related dysphoria, but also dysfunctional attachment styles, altered relational schema, affect dysregulation, overdeveloped avoidance responses (especially substance abuse, dissociation, and tension reduction behaviors), and conditioned cognitive-emotional responses.

This presentation will outline the central aspects of a cognitive-behavioral/relational approach to complex trauma in older adolescents and adults, referred to as the Self-Trauma Model (STM). The STM is a customized, components-based intervention that involves (a) carefully titrated exposure to traumatic material as it arises (or is elicited) during treatment, as opposed to a formal exposure hierarchy or focus on a single traumatic memory, (b) cognitive consideration of archaic trauma-related beliefs and expectations, (c) the development of increased self-capacities (especially identity and affect regulation) so that avoidance behaviors such as substance abuse or tension reduction activities are less necessary for psychological equilibrium, and (d) the reworking of activated relational schema and other implicit memories within the therapeutic relationship. Although most of the components of STM have been empirically validated, the overall model varies considerably according to the specific needs of each client. As a result, the STM is not manualized on a session-by-session basis. However, there is an associated text for its application (Briere and Scott´s [2006]. Principles of trauma therapy: A guide to symptoms, evaluation, and treatment).Videotaped vignettes with an actress will be played at various points in this presentation to illustrate the implementation of specific treatment components.

Narrative Exposure Therapy as a Treatment for Traumatized War Victims: The Evidence

(Abstract #195932)

Symposium/Panel (Civil Ref, Clin Res) **Crystal Room, 3rd Floor**

Neuner, Frank, PhD[1]; **Elbert, Thomas, PhD**[1]; **Martina, Ruf, MA**[1]; **Ertl, Verena, MA**[1]; **Schaal, Susanne, PhD**[1]
[1]*University of Konstanz, Konstanz, Germany*

Traumatic stress due to conflict and war causes major mental health problems in many resource-poor countries. Narrative Exposure Therapy is a pragmatic short-term intervention that has been developed for the field context. The symposium presents data from recent randomized controlled trials.

Treatment of Posttraumatic Stress Disorder by Trained Lay Counselors in an African Refugee Settlement
The objective of this study was to examine whether trained lay counselors can carry out effective treatment of PTSD in a refugee settlement. In a randomized controlled dissemination trial in Uganda with 277 Rwandese and Somali refugees who were diagnosed with PTSD we investigated the effectiveness of psychotherapy administered by lay counselors. Strictly manualised Narrative Exposure Therapy (NET) was compared with more flexible Trauma Counseling (TC) and a no-treatment monitoring group (MG). Less subjects (4%) dropped out of NET treatment than TC (21%). Both active treatment groups were statistically and clinically superior to the monitoring group on PTSD symptoms and physical health, but did not differ from each other. At follow up, a PTSD diagnosis could not be established anymore in 70% of NET and 65% TC participants, whereas only 37% in the monitoring group did not meet PTSD criteria any more. Short-term psychotherapy carried out by lay counselors with limited training can be effective to treat war-related PTSD in a refugee settlement.

Narrative Exposure Therapy Versus Group Interpersonal Psychotherapy—An RCT With Orphans of the Rwandan Genocide
The 1994 genocide of Rwanda has left numerous children orphaned. 11 years later, 26 orphans (age 19±3 yrs) who fulfilled *DSM-IV* diagnosis of PTSD (assessed twice across a period of 6 months) were offered participation in a controlled treatment trial. A group adaptation of Interpersonal Psychotherapy (IPT, n = 14) was compared to Narrative Exposure Therapy (NET, n = 12). Main outcome measures were symptoms of PTSD and depression assessed pre-treatment, 3 months and 6 months after therapy using the CAPS, MINI and Hamilton Rating Scale. At post-test, participants in both treatment conditions showed reductions in posttraumatic stress symptoms and depression symptoms. At 6-month follow-up, NET proved to be more effective in the treatment of PTSD. Only 25% (n = 3) of NET-participants but 71% (n = 10) of the IPT-participants still reached the threshold for PTSD. There was a significant reduction in depression symptoms in both treatment groups, whereby NET again proved to be more effective. This treatment-trial demonstrates that NET and group-IPT are powerful treatment modules even when most severe traumatic stress and difficult living conditions have led to chronic mental suffering.

The Efficacy of KIDNET (Narrative Exposure Therapy for Children) in the Treatment of Traumatized Refugee Children: 6- and 12-Months
In a previous epidemiological study we found that every fifth child who came to Germany accompanying his asylum-seeking parents, suffered from a PTSD according to the *DSM-IV*-Criteria. In a subsequent RCT we evaluated the efficacy of KIDNET – a short-term trauma-focused intervention for traumatized children. 26 refugee children were randomly assigned either to the treatment group or to a waiting list control group. The children´s PTSD symptom severity was assessed before treatment, as well as six and 12 months after treatment using the UCLA PTSD Index for Children. Results of the six-month-follow-up showed that KIDNET is a highly effective intervention in the treatment of traumatized children – especially in child survivors of war and organized violence (F (23)=9.2, p=.006). Six months after treatment the

average symptom score of children treated with KIDNET was reduced from initially 43.3 to 17.2 whereas the waiting list group showed only a small symptom reduction from 38.3 to 33.8 in the post-test. Following the six-month evaluation, KIDNET treatment was also offered to the children in the waiting list control group. The results of the 12-month follow-up confirmed the outcome of the six-month post-test, the average symptom severity remained low and stable over time.

Follow Up of a Randomized Controlled Trial Narrative Exposure Therapy: A Disseminable, Community-Based Treatment Approach for Former Child Soldiers

In the conflict between the rebel group `Lord´s Resistance Army´ and the Ugandan government an estimated 25.000 children were abducted and almost 2 million people forcefully displaced. In an epidemiological survey (n=1121) we examined trauma spectrum disorders and related functional impairment in formerly abducted and war-affected children and youth in 3 Northern Ugandan Districts. Results indicated that 8% (n=432) of the non-abducted and 31% (n=344) of the abducted children and youths suffer from PTSD; rising to 44% if abduction time 1 month (n=151). Thereafter, 60 former child soldiers (mean age=18) suffering from PTSD were enrolled in a dissemination RCT. Treatments were carried out by local counsellors in 8 sessions, comparing NET to an active control-group (education support, ES) and a waiting list (WL). to date results from 3-months post-therapy show a significant reduction of PTSD-symptoms in both active treatment groups with NET being superior to ES, supporting the notion that short-term trauma treatment reduces the suffering of even highly affected groups, like child soldiers and can be effectively disseminated to lay-personnel in (post-)conflict areas. 12-months follow-up data and resulting recommendations will be presented.

Afterdeployment.org: A Self-Guided Education and Skills Building Web Site

(Abstract #196121)

Symposium/Panel (Prev EI, Mil Emer) **Monroe Ballroom, 6th Floor**

Gahm, Gregory, PhD[1]; Ciulla, Robert, PhD[1]; Whealin, Julia M., PhD[2]; Johnson, Patti, PhD[3]; *Ruzek, Josef, PhD*[4]; Kuhn, Eric, PhD[5]

[1]Madigan Army Medical Center, Fort Lewis, Washington, USA
[2]VAPIHCS, National Center for PTSD Pacific Islands Division, Honolulu, Hawaii, USA
[3]Department of Graduate Medical Education, Madigan Army Medical Center, Tacoma, Washington, USA
[4]National Center for PTSD Education and Dissemination Division, Menlo Park, California, USA
[5]Sierra Pacific MIRECC, VA Palo Alto Health Care System, Menlo Park, California, USA

The U.S. military is now faced with a large number of Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) returnees suffering from post-deployment mental health problems (Hoge, 2004). Clinical research shows that cognitive-behavioral intervention in the weeks following trauma can decrease the likelihood of development of PTSD (Bryant et al., 1998, 1999; Litz, 2004). However, issues including geographic dispersion and stigma related to participating in mental health services have presented significant barriers to care for the OIF/OEF population. This panel describes work conceptualizing, developing, and implementing the new Congressionally-funded U.S. Department of Defense website, called afterdeployment.org. The website provides OIF/OEF returnees and their families with self-guided assessment, interactive educational activities, and cognitive-behavioral skills-building workshops on user-friendly topics as varied as sleep, anger, unwanted memories, and children. Panel members will demonstrate the website and will lead a discussion about the benefits and limitations of web-based interventions, including how such interventions can function as personalized, anonymous treatment for individuals who may otherwise not receive care, assist with referral to mental health services, and augment traditional face-to-face clinical practice.

Addressing Child Trauma in Pediatric Medical Settings

(Abstract #196308)

Symposium/Panel (Child, Prev EI) **Salons 7-9, 3rd Floor**

***Kassam-Adams, Nancy, PhD*[1]; McAlister Groves, Betsy, LICSW[2]; Marsac, Meghan, PhD[1]; Landau Fleisher, Courtney, PhD[3]; Kohser, Kristen, MSW[1]**

[1]Center for Injury Research & Prevention, Children's Hospital of Philadelphia, Philadelphia, Pennsylvania, USA
[2]Child Witness to Violence Project, Boston Medical Center, Boston, Massachusetts, USA
[3]Chicago Child Trauma Center, La Rabida Children's Hospital, Chicago, Illinois, USA

Pediatric medical settings offer unique opportunities to identify and address child traumatic stress from medical events or other types of trauma exposure. This symposium will describe multiple approaches to raising awareness, training frontline pediatric health care providers, and integrating trauma-informed services in pediatric settings.

Developing Training for Pediatric Providers About Young Children and Trauma

It is well documented that traumatic experiences in early life may have life-long consequences and that very young children react to highly stressful or traumatic events in ways that compromise the development of attachment relationships and the capacity to regulate emotions. A survey of 1700 children seen in National Child Traumatic Stress Network treatment sites revealed that children who received clinical services experienced an average of three traumas, and that the initial trauma exposure occurred by age five. These findings provide a powerful rationale for the importance of increasing the capacity of pediatric health settings to identify these children at an early age. Betsy McAlister Groves will describe efforts to increase the ability of primary care pediatric providers to identify and respond to young children who are traumatized. She will also describe the development of training materials for use in medical education settings. The presentation will review symptoms of early childhood trauma and findings from surveys and focus groups of medical providers on their knowledge and current practice of identifying trauma in early childhood, and their opinions about what kinds of training materials are useful. Specific elements of a training module for primary care pediatric providers will be presented.

Preventing and Responding to Traumatic Stress: Web-Based Tools for Parents and Health Care Providers

This presentation will describe the process of developing online traumatic stress resources for parents and pediatric health care providers. Our team has developed the "After the Injury" website for parents of injured children, with the aim of supporting parents´ role in secondary prevention of traumatic stress after injury. This site integrates information on injury and traumatic stress, video and audio segments, and interactive features that guide parents to rate their child´s reactions and create an individualized care plan. A website for pediatric health care providers is now under development. This site is designed to deliver broad access to practical tools for addressing medical traumatic stress in children, and to provide skills training in "trauma-informed" pediatric health care. We will describe progress and challenges in developing web-based information and/or interventions, and in evaluating the usability and effectiveness of multi-component websites for lay or professional audiences. Evaluation of the parent site has included two rounds of usability testing (to hone the site´s functionality and ease of use for a broad range of users), as well as qualitative and quantitative evaluations of the site´s impact on parents' understanding of child reactions and their ability to provide optimal coping assistance.

Traumatic Stress Consultation: Establishing Trauma-Focused Services in the PICU

Many aspects of the Pediatric Intensive Care Unit (PICU) and the injuries and illnesses that result in PICU admission are traumatogenic for patients and their caregivers. Traumatic stress reactions during or after PICU admissions are common. While patients´ and caregivers´ coping skills often yield a natural recovery trajectory, a considerable minority develop ASD, PTSD, or traumatic stress symptoms significant enough to warrant intervention. Units generally have supportive services for patients and caregivers, but professionals providing these services frequently report feeling unprepared to sufficiently address the needs. Trauma experts can be valuable consultants in assisting medical and psychosocial professionals to mitigate further trauma exposure, manage symptoms, and secure effective services for patients and families needing specialized care. Engagement strategies, needs assessment, observing unit dynamics, and developing services to meet identified needs are important to successful consultation and collaboration. This presentation will model application of these skills in establishing trauma-focused services in a large, Midwestern, urban PICU. Distinctions between mental health and medical cultures, and strategies to bridge these differences, will be highlighted. Tactics to maximize existing resources while minimizing additional clinical burden will be presented.

Implementing and Evaluating a Stepped Preventive Intervention for Hospitalized Injured Children

Data suggests that 1 in 6 children hospitalized for unintentional injury develops persistent traumatic stress symptoms, and that traumatic stress is associated with poorer health and functional outcomes. The acute medical setting offers opportunities for secondary preventive interventions, but hospital stays are brief and the health care team´s skill and comfort in providing psychosocial screening or intervention is variable. We are implementing and evaluating a stepped preventive intervention designed to be delivered within these constraints. The intervention is delivered by nursing and social work staff and combines systematic screening of injured patients with targeted follow-up for those at risk, and evidence-based interventions that are matched to individual need. A randomized controlled trial (n=270) is evaluating the impact of the intervention on psychosocial (PTSD and depression symptoms) and health outcomes (adherence to medical discharge instructions, health-related quality of life), and will provide preliminary data concerning cost-effectiveness and subsequent health service utilization. This presentation will describe the results of screening for PTSD risk in this large inpatient injury sample, the nature and course of stepped care provided for those who were randomized to treatment, and preliminary follow-up data for the study.

Smoking, Nicotine, and Trauma

(Abstract #196037)

Symposium/Panel (Clin Res, Mil Emer) **Wabash Room, 3rd Floor**

Acheson, Shawn K., PhD[1]; Wilson, Sarah M., BA[2]; Kirby, Angela C., MS[3]; McDonald, Scott D., PhD[3]; *Gulliver, Suzy B., PhD*[4]; Straits-Troster, Kristy A., PhD[5]; Calhoun, Patrick S., PhD[5]; Dennis, Michelle F., BA[6]; Beckham, Jean C., PhD[5]; Lee, Sherman T., BA[7]; Hertzberg, Brian, BA[8]; McClernon, F. Joseph, PhD[9]; Collie, Claire F., PhD[2]; Yeatts, Beth P., PhD[10]; Dedert, Eric A., PhD[6]; Zaborowski, Daphne E., BA[6]

[1]Department of Psychiatry & Behavioral Sciences, Duke University Medical Center, Durham, North Carolina, USA
[2]Durham VA Medical Center, Durham, North Carolina, USA
[3]VA Mid-Atlantic Mental Illness Research, Education and Clinical Center (MIRECC), Durham, North Carolina, USA
[4]Center of Excellence, Bldg. 7 (151C), Waco Veterans Affairs Medical Center, Waco, Texas, USA
[5]Psychology, Duke University and Durham Veterans Affairs Medical Centers, Durham, North Carolina, USA
[6]Duke University Medical Center, Durham, North Carolina, USA
[7]VA Mid-Atlantic Mental Illness Research, Education and Clinical Center (MIRECC) and Duke University Medical Center, Durham, North Carolina, USA
[8]Duke University, Durham, North Carolina, USA
[9]Center for Nicotine and Smoking Cessation Research, Duke University Medical Center, Durham, NC, USA
[10]Durham VA Medical Center, Durham, NC, USA

Using a combination of national public health data and experimental data, we will explore the success of smoking cessation in both military and clinical populations. We will also examine cognitive and mood effects of smoking in smokers with PTSD, as well as the antecedents of relapse in PTSD smokers.

Smoking Among U.S. Veterans Deployed to Iraq/Afghanistan: Health-Related and Demographic Correlates

Tobacco use and related illness among U.S. veterans continues to be a challenge within the VA healthcare system. Although efforts have been made by the Department of Veterans Affairs to reduce the mortality and morbidity associated with tobacco use, little is known about the health-related correlates of tobacco use among recent combat veterans. A nationwide survey of healthcare experiences among VA outpatients (2005 SHEP) provides useful data to address this question. Approximately 21% of OEF/OIF veterans surveyed within the VA healthcare system during FY2005 responded. In this sample, 24% were identified as current smokers and 23% were identified as former smokers. Although the odds of attempting to quit within the last 12 months was ~3 times greater among those that were asked if they wanted to quit by their VA healthcare provider, none of the other demographic, health-related, or time since return from service variables were related to attempt to quit smoking. The odds of long-term abstinence increased with age and active employment and decreased among males and minorities. Time since return from active duty and health-related variables did not differentiate short-term from long-term abstainers. Results highlight the importance of patient-provider communication and its influence upon patient health risk behaviors.

Relapse and Craving During a Smoking Cessation Quit Attempt Among Smokers With and Without PTSD

This study investigated the correlates of cigarette craving and post-quit relapse in smokers with posttraumatic stress disorder (PTSD) using electronic diaries. Seven days of monitoring following a cessation attempt by 28 smokers (15 with PTSD; 13 without PTSD) were collected. 349 craving, 190 smoking lapse, and 347 nonsmoking occasions were compared. PTSD smokers reported a significantly greater smoking craving than non-PTSD smokers during the post-quit week. PTSD individuals reported significantly higher negative affect, number of PTSD symptoms, and severity of PTSD symptoms immediately following smoking relapse occasions when compared with ratings following craving occasions (but no lapse) and nonsmoking occasions. The PTSD

smokers also reported significantly higher negative affect during craving occasions compared to nonsmoking occasions. These results suggest that compared to smokers without PTSD, smokers with PTSD experience higher smoking craving during the first days following a quit attempt. for PTSD smokers, PTSD symptoms and negative affect are significantly related to smoking craving and relapse during smoking cessation. These results are consistent with previous ad lib monitoring studies, and underscore the importance of addressing more intense craving, PTSD symptoms and negative affect as antecedents of relapse among PTSD smokers.

Smoking in Help-Seeking Veterans With PTSD Returning From Iraq and Afghanistan

Past research has shown that veterans and individuals with posttraumatic stress disorder (PTSD) have increased rates of smoking. However, the rates of smoking in younger help-seeking veterans returning from Iraq and Afghanistan, and possible correlates of smoking among this population are unknown. In this study, we evaluated the rate of lifetime and current smoking among a sample of 87 returning male veterans diagnosed with PTSD. Twenty-six percent were lifetime smokers and 29% were current smokers. Current smokers were significantly younger than nonsmokers. Current smokers (mean age = 28) reported a mean age of smoking onset as 15.87 with a pack year history of 7.45. These smokers reported on average one previous quit attempt (with 27% reporting relapse within three days). According to a stages-of-change model, the majority of the smokers were in the contemplation phase of stopping smoking (56%) with 32% in the precontemplation phase and only 12% in the preparation phase. The results are placed in the context of non-psychiatric and psychiatric smokers.

Cigarette Smoking Modulates Mood and Attention in Posttraumatic Stress Disorder

Cigarette smoking is prevalent among those with PTSD. Although PTSD is associated with impairment of attention and memory, the effects of smoking on cognitive functions in PTSD has not been investigated. This study examined the effects of overnight cigarette abstinence on mood and cognition in 16 veterans with PTSD (7 male, 9 female). Participants completed several symptom questionnaires (e.g., Questionnaire on Smoking Urges) and cognitive tasks during two sessions (overnight abstinence vs. overnight abstinence followed by ad lib smoking). Paired-samples t-tests indicated that participants reported significantly more anxiety, negative affect, and cigarette craving in the abstinence session. An increase in PTSD symptoms was also reported, although the effect was not statistically significant. On a task of sustained attention (Connors Continuous Performance Test), abstinence resulted in a more impulsive response style, a more variable response time, and decreased vigilance. Visuospatial working memory (VSWM) was reduced and processing speed (Trail Making Test-A) was faster in the abstinence session, although the differences were not statistically significant. Taken together, these results suggest that cigarette smoking modulates mood, craving, and attention in smokers with PTSD.

Papers
Resilience in the Face of War

Adams Ballroom, 6th Floor

Chair: Nikki R. Wooten, MSW, LCSW-C,
School of Social Work, University of Maryland, Baltimore, Maryland, USA

Predictors of Resiliency and Posttraumatic Stress Disorder Following Traumatic Injury

(Abstract #195920)

Paper Presentation (Bio Med, Prev El)

deRoon-Cassini, Terri, MS[1]; Rusch, Mark, PhD[2]
[1]Psychology, Marquette University, Pewaukee, Wisconsin, USA
[2]Department of Plastic Surgery, Medical College of Wisconsin, Milwaukee, Wisconsin, USA

Over the past 20 years research has focused on psychological factors and person characteristics that increase the risk of developing PTSD following traumatic injury. More recently, research has focused on factors that contribute to resiliency, given that over 50% of individuals do not develop PTSD following single incident trauma. The purpose of this study is to identify peritrauma and immediate posttrauma variables that predict recovery (acute PTSD), delayed PTSD, chronic PTSD, or resiliency in a prospective design across six months for single incident injured trauma (e.g. gunshot wound, physical assault) survivors. One-hundred thirty-eight participants were interviewed immediately posttrauma, and again at four weeks, three months, and six months. Utilizing a logistic regression, the probability of having PTSD compared with resiliency is related to coping self-efficacy, dissociation, and functional impairment ($X2$ (15, 124) = 52.3, $p < .01$). Significant group differences related to depression were found at each time point (F (9, 123) = 5.38, $p<.001$). Assessment and treatment implications are presented with a discussion focused on identifying individuals who may be at heightened risk for psychological distress in the aftermath of trauma.

Measuring Resilience in OIF/OEF Veterans

(Abstract #195258)

Paper Presentation (Clin Res, Asses Dx)

Mavissakalian, Matig, MD[1]
[1]Case Western Reserve University, Brecksville, Ohio, USA

A 10 week psychoeducational workshop (R&R) was designed to promote resources and increase resilience in OIF/OEF (Iraq and Afghanistan veterans) seen at the Cleveland VAMC. The Connor-Davidson Resilience Scale (CD-RISC) a self rating measure ranging from 0-100 with higher scores reflecting greater hardiness, dynamism, self efficacy, patience, humor in the face of adversity, altruism and/or spirituality was administered to the first 34 participants. Repeated measures ANOVA and effect sizes revealed statistically ($p=.005$) and clinically (ES=0.53) significant improvement in 23 completers. Median (65) split comparisons showed greater attrition (8/17 vs 3/17,$p=0.67$) and greater effect sizes (ES=0.77) in the initial lower resilience subgroup. The psychoeducational classes improved resilience to a significant degree in OIF/OEF veterans. The differential effects of initial resilience on outcome highlight the potential usefulness of measuring resilience in future efforts, both at the individual and policy making levels, to improve the retention of OIF/OEF veterans who have the most to gain but tend to drop out from an effective, time limited psycheducational intervention

The Relationship Between Resilience and PTSD: A Test of the Basic-PH Model in the Context of War

(Abstract #195891)

Paper Presentation (Prev EI, Clin Res)

Farchi, Moshe, PhD[1]
[1]*School of Social Work, Tel Hai Academic College, Upper Galilee, Israel*

This study examines the relationship between the Basic-PH model (lahad 1993) and PTSD in the context of war. The Basic-ph model relates to the six major dimensions of coping styles: Belief, Affect, Social, Imagination, Cognition and Physiology. The study sample included 290 male students who participated as active soldiers during the second Lebanon war between Israel and the Hizbulla and 120 female students who volunteered mainly in child care during the war. All students where given the Basic-ph questionnaire (Carlaton, 1996) and a PTSD questionnaire (Foa, 1996). Results indicated a positive strong correlation between coping resources and PTSD. Linear multiple regression indicated that avoidance and numbing where the main predictors of using most of the Basic-ph clusters. This positive relation is assumed to demonstrate that traumatic events encourage the elicitation of coping resources after the traumatic event. Coping resources might exist on a low level before the trauma but the traumatic event enables them to emerge and be useful for the coping person. This study adds the "after shock" coping aspect to Lahad's theory that emphasizes the preliminary importance of strong and stable resilience demonstrated by the Basic-ph clusters.

Deployment Risk Among Women Veterans: Traumatic Experiences and Mental Health Outcomes

(Abstract #195936)

Paper Presentation (Mil Emer, Practice)

Wooten, Nikki R., MSW, LCSW-C[1]
[1]*School of Social Work, University of Maryland, Baltimore, Maryland, USA*

Since the Vietnam War, women´s roles in the armed forces have increased significantly. Evidence suggests women´s participation in military deployments may have adverse effects on their psychosocial, physical, and mental health. This presentation will explore the relationship between deployment risk and mental health outcomes among women veterans including linkages between traumatic experiences, subsequent risk, and gender disparities affecting help-seeking behaviors. A critical analysis of the literature on women veterans emphasizing deployment experiences as well as sociodemographic characteristics increasing women´s risk for adverse post-deployment outcomes will be presented. Traumatic experiences and cumulative risks influencing the development of co-occurring mental health disorders and substance abuse will also be discussed. A synthesis of seminal findings from the Vietnam, Persian Gulf, and Global War on Terrorism conflicts will inform a discussion of implications for future research and practice.

Papers
Child Maltreatment and PTSD

Salon 1, 3rd Floor

Chair: Nicole Nugent, PhD,
Brown Medical School, Providence, Rhode Island, USA

Posttraumatic Stress Symptom Trajectory in Children With Reported Family Violence

(Abstract #196120)

Paper Presentation (Child, Res Meth)

Nugent, Nicole, PhD[1]**; Saunders, Benjamin, PhD**[2]**; Williams, Linda M., PhD**[3]**; Hanson, Rochelle, PhD**[2]**; Smith, Daniel, PhD**[2]**; Fitzgerald, Monica, PhD**[2]
[1]*Brown Medical School, Providence, Rhode Island, USA*
[2]*Medical University of South Carolina, Charleston, South Carolina, USA*
[3]*University of Massachusetts at Lowell, Lowell, Massachusetts, USA*

Most examinations of PTSD development and chronicity, particularly investigations of PTSD in youth, have used variable-centered approaches. The present investigation sought to: (1) identify distinct latent classes of youth PTSD symptom trajectories and (2) examine the impact of one clinically-relevant factor (i.e., parent symptoms of avoidance) on class membership. Participants consisted of 201 (73 boys, 128 girls) youth 7-18 years of age recruited from 530 Navy families following allegations of child sexual abuse, child physical abuse, or intimate partner violence. Using Growth Mixture Modeling (GMM) analyses MPlus Version 4.21, a three-class model was identified as evidenced by progressive decrease BIC values and non-replication of the 4-class solution. Multinomial logistic regression, covarying for child age and sex, indicated that maternal and paternal avoidance significantly predicted child class membership, Pearson Chi-Square (294) = 216.47, p = 1.00; Deviance Chi-Square (294) = 234.28, p= .99. Limitations and implications of this investigation are discussed.

Symptom Development Following Child Maltreatment: Understanding the Role of Attributions

(Abstract #196005)

Paper Presentation (Child, Asses Dx)

Risk, Heather, PsyD[1]**; Hart, Kathleen, PhD, ABPP**[2]
[1]*Department of Psychology, Xavier University, Lexington, Kentucky, USA*
[2]*Department of Psychology, Xavier University, Cincinnati, Ohio, USA*

Victims of child maltreatment present with a variety of psychological symptoms. This study examined the role a child´s attributions for events play in symptom formation. Children (n=67) with and without histories of maltreatment (ages of 7-12) completed measures of general attributional style (Children´s Attributional Style Questionnaire- Revised), abuse-related attributional style (Children´s Attributions and Perceptions Scale), and self-reported symptoms (Beck Youth Inventories). All children were receiving clinical services. We found that negative internal attributions were related to both children´s self-reported internalized symptoms (depression, anxiety, and poor self-concept) and externalized symptoms (anger and disruptive behavior). These results differ from the previous theory that internalized attributional style is related to significant levels of internalized problems, whereas externalized attributions are related to externalized behavior. The current finding has important implications for the assessment and treatment of children who have been abused in that attention may be drawn to their disruptive behavior without attention to the internalized processes (self-blame) that may be contributing to their externalized symptoms. Limitations to this study and implications for future research will be provided.

Emotion Dysregulation and Trauma-Related Internalizing Symptoms After Child Psychological Abuse

(Abstract #195979)

Paper Presentation (Asses Dx, Child)

Coates, Aubrey A., MA[1]; Messman-Moore, Terri, PhD[1]; Volz, Angela R., MA[1]; Gaffey, Kathryn, MA[1]
[1]Miami University, Oxford, Ohio, USA

The complexity involved in defining childhood psychological abuse (CPA) has impeded research on this topic. At times CPA is divided into types which are believed to be conceptually distinct from other types of CPA. Other times CPA is studied without attention to types. It is unclear which approach is empirically supported. If distinct types of CPA exist, certain types may be more salient for the development of later psychological difficulties. This hypothesis was examined in 846 college women. Types of CPA were examined in relation to common long-term psychological difficulties related to CPA: emotional impulsivity, unawareness, and nonacceptance and trauma-related depression and anxiety. Approximately 13% reported experiencing CPA. Results indicated 4 distinct types of CPA: Spurning, Emotional Nonresponsiveness, Corrupting, and Demanding. Results suggest that there may be specific long-term difficulties which develop when particular types of emotionally abusive behavior is experienced. Emotional Nonresponsiveness was related to later emotional unawareness; Spurning was related to trauma-related internalizing symptoms, emotional nonacceptance and impulsivity. Experiences of spurning may be partciularly salient in the development of later emotion dysregulation and internalizing symptoms.

Co-Occurrence of Community Violence and Child Maltreatment: Assessing Risk for PTSD

(Abstract #196262)

Paper Presentation (Child, Cul Div)

Aisenberg, Eugene, PhD[1]; Ayon, Cecilia, MSW[1]; Garcia, Antonio, MSW[1]
[1]Social Work, University of Washington, Seattle, Washington, USA

This presentation examines lifetime exposure to community violence (ECV) among 246 African American, Latino, and White maltreated and 140 non-maltreated adolescents residing in a large urban county. It focuses on three questions: 1) Are maltreated youth at higher risk for ECV than non-maltreated youth? 2) Does maltreatment status differentiate risk for PTSD and behavior problems? 3) While controlling for gender, age, and ethnicity, does maltreatment act as mediator of the effects of ECV upon PTSD and behavior problems?

Subjects reported substantial exposure to at least one violent event (84% as victims and 78.5% as witnesses). Maltreated adolescents were more likely than non-maltreated youth to report a high level of violence exposure. One-third of each group met PTSD criteria. Examination of subscales revealed a statistically significant difference in mean score ($p < .01$) only for hyperarousal score (.19 non-maltreated, .31 maltreated). Maltreated adolescents manifested substantially more behavior problems than the non-maltreated adolescents.

Analyses identified maltreatment is a partial mediator of behavior problems accounting for 6.5% of the variance ($F(7,378) = 3.770$, $p = .001$). Findings underscore the need for systematic assessment of the co-occurrence of community violence exposure among maltreated adolescents to inform prevention and treatment efforts.

Papers
Predictors and Treatment Issues in Children

Salon 3, 3rd Floor

Chair: Lilach Rachamim, MA,
Department of Psychology, Bar Ilan University, Ramat Gan, Israel

Fear Activation and Habituation During Imaginal Exposure in Youth Suffering From PTSD

(Abstract #196109)

Paper Presentation (Clin Res, Child)

Rachamim, Lilach, MA[1]; Helpman, Liat, MA[1]; Foa, Edna, PhD[2]; Shafran, Naama, MA[1]; Daie-Gabai, Ayala, MA[1]; Gilboa-Schechtman, Eva, PhD[1]
[1]Department of Psychology, Bar Ilan University, Ramat Gan, Israel
[2]University of Pennsylvania, Philadelphia, Pennsylvania, USA

No studies to date examined emotional processing (Foa and Kozak, 1986) in youth with PTSD. Meta-cognitive beliefs identified in anxious adolescents (e.g.,"My worrying could make me go mad"), were positively associated with symptoms of anxiety (Cartwright-Hatton, Mathers, Illingworth, Brocki et al., 2004). Thought suppression strategies were used more by adolescents than children (Farrell and Barrett, 2006). These findings suggest that children may not have a meta-cognitive beliefs concerning affective response to re-telling of the trauma story. Therefore, they maybe less likely than adolescents to activate the fear-structure during imaginal exposure (IE). We examined fear activation and habituation in 45 (24 girls) youths (8-18 years) with PTSD, who underwent an adaptation of Prolonged Exposure Treatment for Children and Adolescents (Foa, Chresman, Gilboa-Schechtman 2008). For the whole sample, children and observers reported significant within- and between-session habituation for the first three sessions. Younger children showed lower activation levels, and needed fewer IE sessions to achieve comparable treatment gains. Higher activation levels during the first session predicted better treatment outcome. Implications of developmental considerations for treatment adaptation for youth are discussed.

A Web-Based Early Intervention for Children and Their Parents Following Unintentional Trauma

(Abstract #196196)

Paper Presentation (Prev El, Child)

Cox, Catherine, BA, BSOSCI[1]; Kenardy, Justin, PhD[2]
[1]School of Psychology & Centre of National Research on Disability and Rehabilitation Medicine, University of Queensland, Herston, Queensland, Australia
[2]Centre of National Research on Disability and Rehabilitation Medicine, University of Queensland, Herston, Queensland, Australia

Unintentional trauma in children can result in chronic and severe psychopathology that often goes undetected and untreated. This presentation will outline a randomised control trial that investigated the effectiveness and helpfulness of a web based early intervention aimed at children and their parents following unintentional trauma. Eight-five children aged 7-16 years were recruited from surgical wards and given a questionnaire battery at three time points, (1-2 weeks, 4-6 weeks and 6 months post) assessing traumatic stress reactions and coping. Following the first assessment, children were randomised into either an intervention or control group (treatment as usual). The intervention consisted of a website, designed to assist in normalising reactions, teach coping skills and enhance a child´s strength and resiliency. Parents were provided with an information booklet explaining normal stress reactions and how they can help their child or themselves with the stresses related to the trauma. Data analysis will focus on the differing severity and duration of stress reactions between the groups as well as analyse coping skills employed. A web based intervention is not only cost effective and easily accessible but also places this study at the cutting edge of treating childhood trauma.

Exploring the Relationships Among Dissociation, Victimization and Juvenile Sexual Offending

(Abstract #195825)

Paper Presentation (Child, Asses Dx)

Leibowitz, George, PhD[1]
[1]*University of Vermont, Burlington, Vermont, USA*

An etiological model of dissociation can have utility for researchers and treatment providers working with sexually abusive youth with trauma histories. This presentation explores the relationships among dissociation, victimization, and juvenile sexual offending in two racially/ethnically diverse groups of sexually abusive and general delinquent male adolescents (n=503). Bivariate analysis showed significant correlations between all types of child abuse and dissociation, with the exception of emotional neglect. Hierarchical logistic regression analysis indicated that dissociation was highly significant in predicting sexual offender status. Moreover, dissociation, sexual victimization, and physical abuse showed significant effects in predicting membership in the sexual offender group; however, emotional abuse eliminated the effects of dissociation and the other abuse variables. The results confirmed the need for additional research in the areas of assessment and treatment of dissociation among sexually abusive youth.

Papers
Sleep and Trauma

Salons 4 – 6, 3rd Floor

Chair: Claudia Zayfert, PhD,
Psychiatry, Dartmouth Medical School, Lebanon, New Hampshire, USA

Cognitive Behavioral Social Rhythm Therapy for Veterans With PTSD, Depression, and Insomnia

(Abstract #196210)

Paper Presentation (Clin Res, Mil Emer)

Haynes, Patricia, PhD[1]; Williamson, Marta, MA[1]; Kelly, Monica, BS[2]; Marks, Michael, PhD[3]; Bootzin, Richard, PhD[4]
[1]*University of Arizona, Southern Arizona VA Healthcare System, Tucson, Arizona, USA*
[2]*University of Arizona, Tucson, Arizona, USA*
[3]*Southern Arizona VA Healthcare System, Tucson, Arizona, USA*
[4]*University of Arizona, Tuscon, Arizona, USA*

Patients with PTSD, Major Depressive Disorder (MDD), and insomnia have more severe psychopathology and worse treatment outcomes than patients with only one of these disorders. Although cognitive behavioral interventions are highly effective treatments for each of these problems, few treatments target both sleep and psychiatric symptoms. The purpose of this study was to develop and test an integrative group psychotherapy, Cognitive Behavioral Social Rhythm Therapy (CBSRT), for veterans with these comorbid disorders. CBSRT is a 12-week, 2-hour group therapy designed to improve sleep and increase the frequency and regularity of daily habitual behaviors. to date, 15 veterans with PTSD and MDD have started CBSRT. Throughout the treatment, patients completed the Pittsburgh Sleep Quality Index, PTSD Checklist, and Beck Depression Inventory. Analysis of change trajectories via mixed linear modeling showed that all of these measures improved significantly over time ($p < .01$). By the end of treatment, both MDD and PTSD symptoms reduced by a mean of 10 points, and sleep onset improved by 24 minutes. The majority of patients (80%) experienced a clinically significant change on sleep or depression scores. Overall, these data demonstrate that CBSRT is both feasible to administer and effective for sleep and depression symptoms in veterans with PTSD, MDD, and sleep problems.

The Role of Fear of Sleep and Rumination in the Sleep Disturbance of Patients With PTSD

(Abstract #196018)

Paper Presentation (Clin Res, Practice)

Zayfert, Claudia, PhD[1]; Dryman, M. Taylor, BA[2]; Morris, Kris, PhD[1]; DeViva, Jason, PhD[3]; Pigeon, Wilfred, PhD[4]
[1]*Psychiatry, Dartmouth Medical School, Lebanon, New Hampshire, USA*
[2]*Dartmouth College, Hanover, New Hampshire, USA*
[3]*Newington VAMC, Newington, Connecticut, USA*
[4]*University of Rochester School of Medicine & Dentistry, Rochester, New York, USA*

Patients with PTSD frequently report fear of sleeping. This study examined relationships between fear of sleep and insomnia of patients with posttraumatic stress disorder (PTSD). Patients (n=123) completed the PTSD Checklist, Penn State Worry Questionnaire (PSWQ), Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), and Fear of Sleep Inventory (FOSI, including nightmare avoidance and nighttime vigilance subscales), the Clinician Administered PTSD Scale (CAPS; n = 89) and Insomnia Severity Index (ISI; a measure of impairment due to insomnia). Separate stepwise linear regressions found that only FOSI-NA predicted CAPS13 (insomnia), R2 =.19. and only PSWQ and FOSI-NA predicted ISI, R2 = .39, (PSWQ R2 = .08 and FOSI-NA R2 = .18). An exploratory analysis of patients without nightmares (n = 50) found only PSWQ and FOSI predicted ISI, R2 =30, each contributing unique variance to the prediction of ISI, R2 = .12 and .16, respectively. These findings suggest that the association of nightmares with insomnia in PTSD is largely due to fear of nightmares. Worry/rumination also relates to impairment due to insomnia. For patients not troubled by nightmares, fear of sleep and rumination are prominent factors contributing to sleep-related impairment. Treatment that addresses these factors may improve insomnia of PTSD patients.

Sleep in Healthy Adults With History of Childhood Trauma Exposure

(Abstract #196247)

Paper Presentation (Bio Med, Asses Dx)

Neylan, Thomas, MD[1]; Metzler, Thomas, MS[1]; Henn-Haase, Clare, PsyD[1]; Marmar, Charles, MD[1]
[1]*University of California San Francisco, San Francisco, California, USA*

Childhood trauma exposure is known to have persistent neurobiologic effects on arousal and stress reactivity. Our objective was to test whether subjective and objective sleep measures distinguished subjects with and without childhood trauma exposure in a healthy well characterized sample of police academy recruits who had no current Axis I psychopathology.

Methods: 366 psychologically healthy recruits were evaluated while in police academy training. Subjective sleep quality was indexed by the Pittsburgh Sleep Quality Index (PSQI). A subsample (N= 206) was also assessed with the Insomnia Severity Index (ISI), a scheduled interview for sleep disorders, and 7 days of monitoring with actigraphy.

Results: Subjects with history of childhood trauma (N= 54) had significantly worse subjective sleep quality on the PSQI (t= 2.0, $p < .05$) compared to subjects without childhood trauma exposure (N= 312). Similarly, subjects with childhood trauma had higher scores on the ISI (t= - 2.8, $p < .01$). Childhood trauma exposure was associated with an increased lifetime prevalence of several parasomnias. There were no differences in actigraph estimates of sleep duration, wake after sleep onset, or number of awakenings.

These results are consistent with other studies demonstrating greater persistent effects of trauma exposure on subjective versus objective measures of sleep quality.

Overcoming Treatment Resistant PTSD Nightmares With an Endocannabinoid Receptor Agonist

(Abstract #196336)

Paper Presentation (Practice, Clin Res)

Fraser, George, MD, FRCPC[1]
[1]*Operational Trauma and Stress Support Centre, Canadian Forces, Ottawa, Ontario, Canada*

Treatment resistant nightmares in PTSD represent a distressing problem for a significant number of patients with the disorder. A potential breakthrough in pharmacotherapy may be found in endocannabinoid receptor agonists. Endocannabinoid receptors are the most abundant G-coupled protein receptors in the brain (Pagotto, 2006) and endocannabinoids are thought to exert an effect through a variety of interactions with CNS systems related to PTSD. These include the HPA axis, function of the hippocampus and amygdala, and controlling cortical regulation of memory processes. (Barna, 2004; Jiang, 2004; Chatwal, 2005).
This paper outlines the results of chart reviews of 47 patients diagnosed with PTSD who continued to suffer from nightmares in spite of conventional antidepressant and hypnotic medications. They were introduced to the endocannabinoid receptor agonist nabilone as an adjunct therapy. The majority of patients (72%) receiving nabilone experienced either cessation or a significant reduction in nightmare frequency and severity. Subjective improvement in sleep time, quality of sleep and the reduction of daytime flashbacks and nightsweats were also noted in some patients. The results of this chart review indicate the potential benefits of nabilone, a synthetic cannabinoid, for PTSD patients experiencing poor control of nightmares with standard pharmacotherapy.

Managing Deployment Stress: The Vermont VA/National Guard Program

(Abstract #196513)

Workshop/Case Presentation (Prev El, Commun) **Salons 2, 3rd Floor**

Pomerantz, Andrew, MD[1]; **Gajda, Stanley, MA**[2]; **Slone, Laurie, PhD**[3]
[1]*Veterans Affairs Medical Center, White River Junction, Vermont, USA*
[2]*Veterans Affairs Medical Center, Leeds, Massachusetts, USA*
[3]*National Center for PTSD, White River Junction, Vermont, USA*

The deployment of National Guard and Reserve troops to wars in Iraq and Afghanistan has transformed entire states into virtual military installations. These military families do not have the embedded resources that usually provide support during deployments.

This workshop describes Mental Health inteventions provided by White River Junction's Veterans Affairs (VA) Medical Center, the Vermont National Guard and area community partners for families of National Guard soldiers for the past 4 years.

This model provides interventions before, during and following deployment to meet the needs of guardsmen/women and their families. Utilizing a combination of educational conferences, trainings for commanders, group, family, and individual outpatient sessions, the program helps to prepare soldiers and equips families to deal with the stress of deployment.

The program formed the groundwork for a larger collaborative network that has since facilitated the movement of the treatment model from being solely VA driven to one that is multi-agency and multidisciplinary: The Military, Family & Community Network. This network includes the VT Agency of Human Services and many other community organizations and has bridged gaps in services and enhanced care throughout the region, increasing awareness of readjustment issues and providing maximal community support to military and families.

Concurrent Session 11
Saturday, November 15
9:30 a.m. – 10:45 a.m.

The Genetics of Posttraumatic Stress Disorder: What Do We Know So Far?

(Abstract #195985)

Symposium/Panel (Bio Med, Res Meth) **Grand Ballroom, 4th Floor**

Brunet, Alain, PhD[1]; **Thakur, Geeta Angeli, PhD Candidate**[1]; **Koenen, Karestan C., PhD**[2]; **Lee, Min-Soo, MD, PhD**[3]; ***Joober, Ridha, MD, PhD***[1]; **Amstadter, Ananda, MS**[4]; **Ruggiero, Kenneth, PhD**[5]; **Acierno, Ronald, PhD**[5]; **Galea, Sandro, M.D., DR.P.H., M.P.H**[6]; **Kilpatrick, Dean G., PhD**[5]; **Gelernter, Joel, MD**[7]
[1]*Douglas Mental Health University Institute, McGill University, Verdun, Quebec, Canada*
[2]*Departments of Society, Human Development and Health and Epidemiology, Harvard University, Boston, Massachusetts, USA*
[3]*Department of Psychiatry and Depression Center, Korea University College of Medicine, Seoul, Seongbuk-gu, South Korea*
[4]*Auburn University, Auburn, Alabama, USA*
[5]*Department of Psychiatry, Medical University of South Carolina, Charleston, South Carolina, USA*
[6]*Department of Epidemiology, University of Michigan, Ann Arbor, Michigan, USA*
[7]*Departments of Psychiatry, Genetics, and Neurobiology, Yale University, West Haven, Connecticut, USA*

It is now well understood that genetic factors play a significant role in the etiology of Posttraumatic stress disorder (PTSD). However, little is still known about which specific genes are involved in the development and persistence of the disorder. Here, we will review the literature in the field of genetics and PTSD, present current findings to highlight the importance of investigating various genes in relation to PTSD and recommend areas of future research that will allow for a better understanding of the underlying pathophysiology of the disorder.

Association Between Posttraumatic Stress Disorder and the 5-HTTLPR Polymorphism
Posttraumatic stress disorder (PTSD) is an anxiety disorder affecting individuals who have suffered a severe traumatic event involving a serious threat to self or to others. Research now indicates that approximately 1 in 10 individuals are affected by PTSD. So far, molecular genetic studies relating various genetic polymorphisms to the development and persistence of PTSD have been scarce. We investigated the association between PTSD and the serotonin transporter polymorphism (5-HTTLPR). DNA was extracted from 41 trauma-exposed individuals who had recently suffered a severe motor vehicle accident and the 5-HTTLPR polymorphism was genotyped. Subjects with the ll genotype were more likely to develop chronic PTSD at Time 1 compared to those with the ss and *sl* genotypes (p=0.06). Furthermore, subjects with the ss and sl genotypes were less likely to suffer from chronic PTSD after being exposed to trauma compared to the ll homozygotes (p=0.04). In this unique prospective study, the s allele of the 5-HTTLPR appears to be acting as a protective factor against the development and persistence of PTSD.

Association Between *RGS2* and Generalized Anxiety Disorder in an Epidemiologic Sample of Hurricane-Exposed Adults
Generalized anxiety disorder (GAD) is a common and sometimes disabling condition often associated with stressful life events that involve significant loss or danger. The disorder appears moderately heritable. Polymorphisms in the *RGS2* (regulator of G-protein signaling 2) gene were recently associated with anxious behavior in mice and panic disorder and trait anxiety in humans. We examined whether rs4606, a single nucleotide polymorphism (SNP) in the 3´ UTR of RGS2, was associated with GAD in 607 adults from the 2004 Florida Hurricane Study who returned buccal DNA samples via mail. Participants were selected via random digit dialing procedures and interviewed via telephone. The outcome

measure was *DSM-IV* diagnosis of GAD derived from structured interviews.*RGS2* SNP rs4606 was significantly associated with GAD in this sample. In logistic regression analyses, each C allele was associated with a 100% (p=.026) increased risk of GAD after controlling for age, sex, ancestry, hurricane exposure and social support. These findings point toward a relevant polymorphism for GAD at the 3′ end of the *RGS2* gene; and suggest that studying a recently disaster-exposed sample is both feasible and may improve power to find gene-disorder associations.

Psychosocial and Genetic Susceptibility to Posttraumatic Stress Disorder
Posttraumatic stress disorder (PTSD) is an often-disabling psychiatric disorder resulting from exposure to trauma and develops in a subset of persons exposed to traumatic stress, suggesting individual differences for susceptibility to PTSD. We found that personal characteristics such as lower educational level, divorced or widowed marital status, and F and clinical scale elevations on the MMPI, were associated with symptoms of disaster survivors. Psychological vulnerability can affect the severity of PTSD. We also analyzed genotype and allele frequencies of candidate genes in PTSD patients and unrelated healthy controls using a case-control design and found that frequencies of 5-HTTLPR s/s genotype and the GG genotype of 5-HTR2A gene were significantly higher in PTSD patients than controls, however the levels of statistical significance were not high. Genotype and allele frequencies for the BDNF and DRD2 gene polymorphisms did not differ between PTSD patients and controls. Overall, it might be necessary to evaluate the possible involvement of as-yet-uncovered gene(s) that influence susceptibility to PTSD and to consider gene-gene, gene-personality, and gene-environment interactions. *Supported by Korea Health 21 R&D Project, Ministry of Health & Welfare, Republic of Korea (03-PJ10-PG13-GD01-0002)

Converging Evidence for Developmental Trauma Disorder: Empirical Support From Large Databases

(Abstract #196087)

Symposium/Panel (Child, Asses Dx) **State Ballroom, 4th Floor**

Stolbach, Bradley C., PhD[1]; Putnam, Frank, MD[2]; Perry, Melissa, DSC[3]; Putnam, Karen, MS[4]; Harris, William, PhD[5]; Kisiel, Cassandra, PhD[6]; Fehrenbach, Tracy, PhD[6]; McClelland, Gary, PhD[6]; Griffin, Gene, JD, PhD[6]; Pynoos, Robert, MD[7]; Fairbank, John, PhD[8]; Briggs-King, Ernestine, PhD[9]; *van der Kolk, Bessel, MD*[10]

[1]Chicago Child Trauma Center, La Rabida Children's Hospital/University of Chicago, Chicago, Illinois, USA
[2]Children's Hospital Medical Center of Cincinnati, Cincinnati, Ohio, USA
[3]School of Public Health, Harvard University, Cambridge, Massachusetts, USA
[4]Department of Epidemiology and Environmental Health, University of Cincinnati, Cincinnati, Ohio, USA
[5]Children's Research and Education Institute, Belmont, Massachusetts, USA
[6]Department of Psychiatry & Behavioral Sciences, Northwestern University Feinberg School of Medicine, Chicago, Illinois, USA
[7]University of California, Los Angeles, Los Angeles, California, USA
[8]Duke University, Durham, North Carolina, USA
[9]Duke University, Durham, North Carolina, USA
[10]Boston University, Boston, Massachusetts, USA

This symposium presents findings of studies of 5,500 adults, 5,000 foster children, and 8,000 children served at child trauma centers. All three studies suggest that complex relational trauma in childhood is associated with an array of developmental impairments, adaptations, and comorbidities, highlighting the need for a new Developmental Trauma Disorder diagnosis.

Childhood Antecedents of Clinical Complexity
The National Comorbidity Survey-Replication is a nationally representative survey of US households (N=5692) using a structured interview to assess 26 lifetime *DSM-IV* diagnoses as well as childhood antecedents including: sexual abuse, physical abuse, parental depression, parental substance abuse, crime victim, and high school dropout. An "ACE-type" analysis was performed with respect to the impact of childhood abuse, trauma, and household dysfunction on the number of *DSM* diagnoses received. As Cumulative Risk Scores (CRS) increased from 0 to 4 or more, the mean number of *DSM* diagnoses per individual increased from 1.4 (SE±0.04, N=3269) to 7.5 (SE±0.62, N=85) replicating the stepwise, dose-response pattern seen in the ACE studies. The pattern of diagnoses differed for males and females with PTSD being diagnosed in 20% or more of females starting at the CRS=2 level. In males, PTSD was not a common diagnosis even at the CR=4+ level. A history of childhood sexual abuse significantly increased likelihood for 18 of the 26 diagnoses in males (mean OR=3.3) and for 23 of the 26 diagnoses in females (mean OR=3.0). These analyses of a nationally representative adult sample demonstrate that childhood trauma and family dysfunction are associated with complex psychiatric profiles characterized by multiple *DSM* diagnoses.

Symptoms of Developmental Trauma Disorder in a Sample of Youth Entering the Child Welfare System in Illinois
To demonstrate the utility of a Developmental Trauma Disorder (DTD) diagnosis, patterns of trauma exposure and symptoms associated with complex trauma and DTD will be identified within a large data set in Illinois. The present study consisted of data collected since July 2005, in conjunction with the Illinois Department of Children and Family Services (IDCFS). An Integrated Assessment was conducted on each child upon entry into the child welfare system, including a comprehensive evaluation of safety, health and mental health needs. The centerpiece of the mental health assessment is the IDCFS Child and Adolescent Needs and Strengths Comprehensive, an instrument used for assessment, treatment and service planning. The sample included 5,000 youth (ages 0-18). Factor analyses were conducted according to the indicators for each domain of complex trauma. Results suggest that different patterns of traumatic experiences, including combinations of violent (sexual abuse, physical abuse and family violence) and non-violent (neglect and emotional abuse) interpersonal trauma are associated with different response patterns across domains of complex trauma. Additionally, these patterns of response manifest differently across developmental stages. These findings will be discussed in terms of their implications and empirical support offered for Developmental Trauma Disorder

Trauma Exposure, Adverse Experiences, and Diverse Symptom Profiles in a National Sample of Traumatized Children
This study utilizes the Core Data Set (CDS) of the National Child Traumatic Stress Network (NCTSN) to evaluate evidence for a Developmental Trauma Disorder among children with histories of multiple chronic traumas and other adverse experiences. The CDS includes initial data from over 8,000 children and adolescents served at 43 NCTSN treatment sites, as well as treatment or post-treatment data from over 4,000. The CDS gathers detailed trauma history profiles that include information on a broad range of adverse experiences and utilizes the Trauma Symptom Checklist for Children, the UCLA Reaction Index for PTSD, the Child Behavior Checklist, and clinician reports of symptoms, diagnoses, functional impairments, services, and demographic information. In this sample, Trauma History Profiles and ACE indicators were related to changes in symptom profiles and increases in behavioral disturbances such as suicidal behaviors. Although approximately 70% of the children in this sample had multiple trauma exposures or complex trauma histories, fewer than 30% were reported to meet *DSM-IV* criteria for PTSD, highlighting the need for a diagnostic formulation that can more effectively account for their complex symptom profiles and wide range of developmental, behavioral and emotional impairments.

How to Overcome Military Members' Mental Health Stigma and Barriers to Care

(Abstract #196093)

Symposium/Panel (Mil Emer, Clin Res) **Adams Ballroom, 6th Floor**

Slone, Laurie, PhD[1]; *Friedman, Matthew, MD, PhD*[2]; Southwick, Steven M., MD[3]; Stecker, Tracy, PhD[4]; Washam, Terry, LISW, DCSW[5]
[1]VA National Center for PTSD, White River Junction, Vermont, USA
[2]VA National Center for PTSD, White River Junction, Vermont, USA
[3]Clinical Neurosciences Division, VA National Center for PTSD, West Haven, Connecticut, USA
[4]Department of Community and Family Medicine, Psychiatric Research Center, Lebanon, New Hampshire, USA
[5]VHA/DoD Outreach Office, VA Central Office, Avon, Ohio, USA

Following deployment, veterans face barriers that prevent them from seeking treatment. Research and practical advice are presented with the goal of helping Service Members acquire the care that they need, including a discussion led by Dr. Matthew Friedman covering the pros and cons of strategies presented.

Barriers to Mental Health Care Among OEF/OIF Veterans Presenting at VA
Hoge et al. (2004) identified specific barriers to receiving mental health care among OEF/OIF veterans. Some barriers were related to education, outreach and resources (e.g. "I don´t know where to get help"), others to perceived stigma (e.g. I would be seen as weak"), and others centered on beliefs soldiers held about mental healthcare in general (e.g. "I don´t believe that mental health care is beneficial."). Dr. Steve Southwick will discuss new research on barriers to receiving care among OEF/OIF veterans who present to a VA hospital.

Purpose: to assess the relationship between treatment seeking, beliefs about mental health care and potential barriers to receiving mental health care among OEF/OIF veterans.

Methods: Participants include OEF/OIF veterans who present to primary care clinics/ mental hygiene clinic and agree to participate in research about barriers to care (perceived personal barriers, institutional barriers, beliefs about psychotherapy, beliefs about medication and fear of loss of vigilance.)

Results and conclusion: We analyze the relationship between barriers to care and degree of traumatic exposure, degree and types of symptomatology (PTSD, depression, alcohol), level of psychosocial function, perceived unit support, stress resilience, interest in receiving mental health treatment and history of mental health treatment.

Predicting Treatment Seeking in OIF National Guard Soldiers
Stigma about mental health treatment can interfere with decisions to seek care. Dr. Tracy Stecker discusses research (NIMH 1R34MH078898-01) conceptualized using the Theory of Planned Behavior (TPB), a model to understand the relationship between beliefs & behavior. The purpose of this research was to create a psychometrically-sound, theoretically-based instrument to assess beliefs about mental health treatment to understand treatment seeking behavior among National Guard soldiers returning from Iraq.

Methods: National Guard soldiers who screened positive for mental health problems on the MINI (N=150) completed a scale designed from the TPB assessing beliefs about mental health treatment (including behavioral, normative & control beliefs, e.g. treatment helps reduce symptoms, work would support my seeking treatment), intention to seek treatment, and treatment seeking behavior.

Results and conclusion: The instrument was found to have high internal reliability & good test-retest reliability. Beliefs about mental health treatment differentiated between soldiers who sought treatment and those who did not. Theoretically, behavioral & control beliefs predicted intention to seek treatment and actual engagement into care. Findings suggest that interventions must be directed toward cognitive factors that motivate treatment seeking in addition to traditionally targeted structural barriers.

VA's Reserve Components PDHRA Partnership with DoD—Overcoming Barriers to Care Among the Reserve & National Guard
The Assistant Secretary of Defense for Health Affairs mandated the Post-Deployment Health Reassessment (PDHRA) Program in March 2005. The PDHRA is a global health screening and functions as part of DoD's deployment-related continuum of care completed between 90-180 days post-deployment. The PDHRA is offered to all Service Members who have returned from operational deployment to include both Active and Reserve Components. Col Terry Washam will discuss key elements of PDHRA's mission: Outreach; early identification; education; and access to care.

The Global War on Terror (GWOT) is relying heavily upon the Reserve & National Guard Forces (Reserve Components). Historically they have comprised 30-50% of combat forces in Afghanistan and Iraq. DoD's reliance on the Reserve Components along with their geographical distribution and combat-related health care needs made a DoD partnership with VA a necessity for successful implementation of the PDHRA with Reserve Components.

Discussant Dr. Matthew Friedman, Executive Director of the VA's National Center for PTSD will lead a discussion covering the pros and cons of various strategies to help overcome the barriers to care that service members face.

Predicting and Treating Posttraumatic Stress in Injured Children

(Abstract #196115)

Symposium/Panel (Child, Clin Res) **Salons 7-9, 3rd Floor**

Nixon, Reg, PhD[1]; McKinnon, Anna, BPSYCH(HONS)[2]; Le Brocque, Robyne, PhD[3]; Kassam-Adams, Nancy, PhD[4]; Kenardy, Justin, PhD[3]; Winston, Flaura, PhD[4]; Hendrikz, Joan, BSC[3]
[1]School of Psychology, Flinders University of South Australia, Adelaide, South Australia, Australia
[2]School of Psychology, Flinders University Australia, Adelaide, Australia
[3]Centre of National Research on Disability and Rehabilitation, University of Queensland, Australia, Herston, Queensland, Australia
[4]Center for Injury Research & Prevention, Children's Hospital of Philadelphia, Philadelphia, Pennsylvania, USA

Injury leading to hospitalisation is one of the most common traumas that children will experience that can lead to posttraumatic stress disorders. Over 4 presentations this symposium will report on research from the USA and Australia that aims to identify children most at risk of developing PTSD after such injuries and the outcomes of interventions designed to either prevent the development of PTSD, as well as a randomised trial for children who have already developed disorder.

The Influence of Memory Processes on the Development and Maintenance of Posttraumatic Stress Symptoms in Children
How traumatic experiences are encoded and re-experienced is argued to be a critical component in determining adjustment following trauma (Ehlers & Clark, 2000). The findings of two studies exploring the role of data-driven processing and perceptions of memory quality in the development and maintenance of posttraumatic stress (PTSS) reactions will be reported. In Study 1, 75 children (7 - 16 years) were interviewed within 4 weeks of an injury leading to hospital treatment. Results indicated that perceptions of memory quality and data-driven processing predicted acute stress symptoms. Study 2 is in progress. Children are interviewed within 4 weeks of their hospital injury (Time 1; T1) and 8 weeks later (Time 2; T2). Preliminary results (N = 50) reveal that, contrary to Study 1, T1 data-driven processing and perceptions of memory quality at T1 do not predict T2 PTSS reactions, after accounting for event-related fear, but initial trauma-related cognitions do. However, after controlling for initial acute stress reactions, T2 perceptions of memory quality (but

not trauma-cognitions) significantly predict later PTSS reactions. The findings suggest these variables have a differential influence on the onset and maintenance of PTSS respectively. The results are discussed in the context of cognitive models of child PTSD.

The Course of Posttraumatic Stress Disorder: An Exploration of Recovery Trajectories of Children and Their Parents Following Accidental Injury

Objective: Although researchers have observed varying rates of symptoms of PTSD following trauma, few studies have explored individual recovery patterns. This paper explores the trajectories patterns for symptoms of Posttraumatic stress in children and parents following child accidental injury.

Method: Data for this study comes from a prospective study of 191 children aged 7-15 years admitted to hospital in Brisbane, Australia, and their parent. Analyses utilized a generalized, semi-parametric, mixture model to identify number and shape of trajectories describing the course of PTSD symtoms for two years following child trauma. PTSD symptoms were assessed using the adult and child version of the Impact of Events Scale (IES).

Results: Results showed three distinct trajectories for children´s psychological response to traumatic injury: (i) well below the clinical level, (ii) above clinical level in the first 4-6 weeks then declined to below clinical level, or (iii) above the clinical level. Parent symptoms were characterized by three similar trajectories although all parents had symptoms below clinical level by six months.

Conclusion: The ability to identify distinct PTSD trajectories post child trauma and the correlates of these trajectory groups has critical clinical implications for the early identification of individuals who may be at risk.

Evaluating Information and Psycho-Education as Secondary Prevention After Pediatric Injury

Informational interventions have the potential to be an accessible and cost-effective means of reducing the impact of potentially traumatic events. Several studies have found that trauma informational materials are appreciated and perceived as helpful by users. Evidence to date has been inconsistent regarding the effectiveness of such materials in preventing or reducing the severity of posttraumatic stress symptoms. As part of an ongoing research program on secondary prevention of traumatic stress after pediatric injury, our team has developed a set of informational and psychoeducational materials for parents of injured children, including print materials, a brief multi-segment video, and an interactive website. The website combines practical information about injury recovery with video segments and interactive features allowing parents to rate child reactions and create an individual care plan for helping their child. This presentation will report the results of a series of evaluations of the print, video, and web materials: a randomized trial of print materials (n=120); and qualitative and quantitative evaluations of video and web-based materials now underway. Each study aimed to understand how parents use the materials, and their potential impact on parent awareness of traumatic stress reactions and the coping assistance provided by parents to their injured children.

A Comparison of Cognitive Behavior Therapy Versus Cognitive Therapy for Childhood PTSD

At present, the majority of randomised controlled trials of CBT for childhood PTSD have been for sexually abused samples. Preliminary findings will be presented for a randomised treatment trial of childhood PTSD following motor vehicle accidents and nonsexual assault. The study has two aims: (a) to examine the efficacy of treatment for nonsexual assault trauma in children and (b) to examine whether cognitive therapy alone can achieve outcomes comparable to a full CBT intervention. Given that CBT for PTSD typically involves imaginal and *in vivo* exposure, it is possible that some children will not tolerate such treatment components, and thus not respond to treatment. Similarly, there is evidence that clinicians in the field often do not use exposure techniques despite their empirical support. At the time of writing, 28 families have entered treatment. Preliminary results indicate that there is little difference between the CBT and CT groups posttreatment in terms of PTSD, depression, maladaptive beliefs, and general anxiety. Overall children demonstrated clinically significant reductions in symptoms following treatment (pre-post effect sizes for PTSD and depression are 2.17 and 0.65, respectively). The role that parents can play in assisting children to manage their posttrauma reactions will be discussed.

Mindfulness, Meditation, and CBT: Similarities and Differences

(Abstract #196315)

Symposium/Panel (Clin Res, Practice) **Wabash Room, 3rd Floor**

Waelde, Lynn C., PhD[1]; Klunk-Gillis, Julie, PhD[2]; *Niles, Barbara, PhD*[2]; Batten, Sonja, PhD[3]; Walser, Robyn, PhD[4]
[1]*Pacific Graduate School of Psychology, Redwood City, California, USA*
[2]*National Center for PTSD, Behavioral Sciences Division, VA Boston Healthcare System, Boston, Massachusetts, USA*
[3]*Trauma Recovery Programs, VA Maryland Healthcare System, Baltimore, Maryland, USA*
[4]*National Center for PTSD, Education Division, VA Palo Alto Health Care System, Menlo Park, California, USA*

Current interest in mindfulness and meditation as PTSD interventions raises questions: 1) Does mindfulness overlap with CBT? 2) Does mindfulness interfere with or promote trauma-related avoidance? 3) Should mindfulness be adjunctive to CBT or offered as a stand-alone treatment? We will present research and clinical findings to address these issues.

Possible Mechanisms of Mindfulness and Meditation as PTSD Interventions

There has been recent speculation that mindfulness, meditation, and cognitive behavioral therapy (CBT) share similar mechanisms. Baer (2003) reviewed evidence that mindfulness might promote a range of cognitive behavioral benefits, including exposure, cognitive change, increased self-management skills, and relaxation. Thus, meditation, like CBT, may reduce reexperiencing distress and avoidance of trauma reminders. In addition, the relaxation entailed in mindfulness and meditation practice may confer additional benefits. Taylor and colleagues (2003) proposed that relaxation may help PTSD symptoms because it reduces hyperarousal, which in turn reduces distress and the concomitant need for avoidance. Findings from our studies of meditation for dementia caregivers (Waelde, Thompson, & Gallagher-Thompson, 2004) and Hurricane Katrina survivors (Waelde et al., in submission) will illustrate the possible effects of meditation on cognitive change and PTSD symptoms, though further research is needed to investigate the efficacy and mechanisms of mindfulness and meditation for PTSD.

Mindfulness as a "Complementary" Treatment for Posttraumatic Stress Disorder

Empirically validated cognitive-behavioral treatments for PTSD have not traditionally included mindfulness meditation as an intervention or a component of treatment. An 8-week telehealth treatment for PTSD modeled after Mindfulness Based Stress Reduction (MBSR; Kabat-Zinn, 1990) was evaluated in a pilot study conducted in a cognitive-behavioral PTSD clinic setting. This presentation will detail some of the challenges encountered and lessons learned from introducing the concepts of mindfulness to the clients participating in the study and the clinic staff. Both differences and similarities between mindfulness and cognitive-behavioral approaches became apparent during the course of the pilot study. For example, in dealing with difficult thoughts and feelings, an MBSR-informed approach would likely focus on allowing or acknowledging the difficulty and "letting it be." By contrast a more traditional CBT approach would be to challenge the negative thought or emotion. On the other hand, a mindfulness intervention can also complement a cognitive-behavioral approach as they both endeavor to decrease avoidance. In addition, both cognitive-behavioral and mindfulness approaches

emphasize choice in actions and thoughts, rather than automaticity, and encourage exploration of alternative ways of responding to thoughts and feelings.

The Role of Mindful Awareness in Facilitating Committed Action
One of the essentials of third wave behavior therapies, such as Acceptance and Commitment Therapy and Dialectical Behavior Therapy is mindful, present-moment awareness. Mindfulness allows one to disrupt avoidance and helps one not to escalate in emotionally challenging situations, while providing the space in which to make choices that are aligned with one's values. Some traditional CBT approaches begin with an assumption that being aware of the pros and cons or potential consequences of an action can be enough to guide behavior. However, everyone has the experience of being fully aware of what "should" be done, while following through with a less adaptive response. Trauma survivors are motivated to avoid difficult thoughts, feelings, and bodily sensations, and avoidance has been proposed as one of the key factors in PTSD (Batten, Orsillo, and Walser, 2005). Thus, mindful awareness of these difficult private events is key for trauma survivors looking to transform their lives from one focused on short-term reductions in difficult emotions and sensations, to one focused on a long-term path of valued choices and actions. Examples of using mindfulness in session with trauma survivors will be provided, contrasted with more traditional CBT approaches to trauma treatment.

Use of Mindfulness in Treating PTSD
In the last several years, there has been considerable research into the use of mindfulness in treating a number of conditions including stress, medical disorders, mood disturbance, cardio-vascular and gastrointestinal problems, and has more recently been applied to posttraumatic stress disorder (PTSD). These findings supported broad generalizability for the use of mindfulness. A modern definition of mindfulness is “the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment” (Kabat-Zinn, 2003, p. 145). We have been using mindfulness in our women´s inpatient trauma treatment program and have had some successes plus we have learned some valuable lessons. We will discuss the use of mindfulness with individuals who carry a diagnosis of PTSD plus explore some of the issues in using mindfulness with this population.

Papers
Cross-Cultural Assessment and Field Research

Crystal Room, 3rd Floor

Chair: Julia Mueller, PhD,
Department of Psychiatry, University Hospital Zurich, Zurich, Switzerland

Multilingual Computerized Diagnostics in Traumatized Refugees: Validity and Acceptance of MultiCASI

(Abstract #196065)

Paper Presentation (Asses Dx, Clin Res) **Crystal Room, 3rd Floor**

Mueller, Julia, PhD[1]; Knaevelsrud, Christine, PhD[2]
[1]Department of Psychiatry, University Hospital Zurich, Zurich, Switzerland
[2]Treament Center for torture Victims Berlin, Berlin, Germany

Migrants and refugees often don´t receive the health care they need due to lacking clinical information on their health status. Illiteracy and multilingualism make standardized psychological assessment methodologically difficult and resource consuming. We developed a multilingual computer assisted self-interview (MultiCASI) allowing psychodiagnostic assessment in diverse languages for persons with varying literacy skills.

Aim of the study was to validate MultiCASI in examining its feasibility, usability, and acceptability in a clinical sample of traumatized refugees. Also we were interested if the use of MultiCASI would increase reports of sensitive information.

We randomly assigned N=67 treatment seeking traumatized refugees (13 countries, 58% male, mean age 38 years) undergoing our institution´s quality management assessment procedures to either the conditions MultiCASI or Interviewer-Administered Questionnaire (IAQ). Mental health (HSCL, PDS), quality of life (Eurohis), socio-demographics and MultiCASi-acceptance were assessed. The questionnaires were translated into 12 languages and recorded in MultiCASI.

Severity of PTSD, depression, anxiety and the reported number of traumatic events were equal in both diagnostic conditions. Patients and therapists accepted MultiCASI well. MultiCASI proved to be a valid, time and cost saving alternative to IAQ assessment.

HIV-Related Stigma and Concerns in Relation to Distress Among Malawi Women

(Abstract #195644)

Paper Presentation (Cul Div, Sos Ethic) **Crystal Room, 3rd Floor**

Khaylis, Anna, MS[1]; Shenkman, Tammy, BA[2]; Wiener, Sarah, BS[3]; Arganbright, Jill, BS[3]; Koopman, Cheryl, PhD[2]; Gore-Felton, Cheryl, PhD[4]
[1]Department of Psychiatry and Behavioral Medicine, Stanford University, Palo Alto, California, USA
[2]Stanford University, Palo Alto, California, USA
[3]Medical College of Wisconsin, Milwaukee, Wisconsin, USA
[4]Stanford University, Stanford, California, USA

This study examined the following hypotheses in a community-based sample of sexually active Malawi women: 1) perception of greater HIV stigma would be associated with more emotional distress; 2) worry about being HIV-positive and worry about the possibility of infecting others would be related to greater emotional distress; and 3) among those who had experienced interpersonal violence, compared to those who had not experienced interpersonal violence, there would be greater perception of HIV stigma. Forty five of 46 women ages 17-46 recruited from the Namitete area of Malawi who had been sexually active within the past two months completed the Malawi Health Behavior Survey, the Center for Epidemiological Studies – Depression scale and the mini Behavior Symptom Inventory. Women who reported greater worry about having HIV and viewed HIV as more stigmatized reported significantly greater depression and anxiety. Women who had been physically abused by their partners also reported significantly greater anxiety. These findings highlight the importance of addressing HIV stigma and HIV-related concerns as well as intimate partner violence in addressing women´s mental health in Malawi.

Spirit Possession as an Idiom of Distress, Coping With the Aftermath of Terror and Trauma in Uganda

(Abstract #196519)

Paper Presentation (Cul Div, Asses Dx) **Crystal Room, 3rd Floor**

Van Duijl, Marjolein, MD[1]; de Jong, Joop, MD, PhD[2]; Nijenhuis, Ellert, PhD[3]
[1]Clinic for traumatized refugees, Center 45, Rijnsburg, Netherlands
[2]Vrije Universiteit Amsterdam, Boston University School of Medicine, Amsterdam, Netherlands
[3]GGZ Drenthe, Assen, Netherlands

Background: Like many African countries Uganda has suffered a history of terror causing societal disruption. Little research has been done on local idioms of distress such as spirit possession and subsequent help seeking behavior, and how this is related to potentially traumatic experiences.

Purpose: To explore the characteristics of spirit possession and its relationship with reported potentially traumatizing events.

Method: 119 possessed patients of traditional healers were compared to a control group of 71 persons. Interviews covered demographic features, questionnaires on the history of symptoms, explantions and help seeking behavior, and measures of dissociation (DES, SDQ) and traumatic experiences (HTQ).

Results: Symptoms of spirit possession in Uganda overlap with experimental criteria for possessive trance disorder in the *DSM IV*. Somatoform complaints often precede typical dissociative and possessive trance symptoms. The relationship between spirit possession and reported trauma is high.

Most patients first sought help from hospitals and health centers before turning to traditional healers. Through traditional healing practices they improved without their traumatic experiences being discussed.

Conclusions: Spirit possession deserves more interest as an idiom of distress related to potentially traumatizing experiences.

Readiness to Reconcile and Mental Health in Traumatized Refugees

(Abstract #196227)

Paper Presentation (Civil Ref, Asses Dx) **Crystal Room, 3rd Floor**

Knaevelsrud, Christine, PhD[1]; Boettche, Maria, MA[1]; Neuner, Frank, PhD[2]; Stammel, Nadine, MA[3]
[1]Treatment Center for torture Victims, Berlin, Germany
[2]University of Konstanz, Konstanz, Baden Württemberg, Germany
[3]Treatment Center for Torture Victims Berlin & University of Konstanz, Berlin, Germany

It is assumed that reconciliation has a positive effect on mental health in victims of human right violations. However, no assessment instrument exists so far. Therefore we constructed a questionnaire to assess the readiness to reconcile with the perpetrators. The sample (N=60) consisted of Kurdish refugees from Turkey. Factor Analysis revealed 3 questionnaire subscales. Reliability was high (Cronbach´s =.88). Validity was proved with Monotrait-Multimethod. Low correlations between the readiness to reconcile and PTSD (r=-.076; p=.65), Depression (r=-,284; p=.115), Anxiety (r=-.275; p=.127) and Quality of Life (r=,174; p=,311) were found.

Results indicate that there is no relationship between PTSD and the readiness to reconcile and only low associations between mental health and readiness to reconcile in Kurdish victims of human right violations.

Papers
Research Issues and PTSD Factor Structure

Monroe Ballroom, 6th Floor

Chair: Katherine Iverson, MA,
National Center for PTSD, VA Boston Healthcare System, Boston, Massachusetts, USA

Trauma Victim: Yes or No? Why it May be Difficult to Answer Traumatic Event Screening Questionnaires

(Abstract #195969)

Paper Presentation (Res Meth, Asses Dx)

Thoresen, Siri, PhD[1]; ÖVerlien, Carolina, PhD[1]
[1]Norwegian Centre for Violence and Traumatic Stress Studies, Oslo, Norway

Reliable measurement of potentially traumatic events (PTEs) is important for traumatic stress research. However, previous studies have found informants´ self reports of PTEs to be relatively unstable over time. The objective of this study was to identify if, and why, informants may find it difficult to choose between a "yes" and a "no" answer to PTE questions. In a nonrepresentative pilot web survey, using qualitative and quantitative methods, community women (N = 628) answered a 13-item PTE screening instrument (SLESQ-Adapted); identified which, if any, questions they found difficult to answer; and described why it was difficult. The majority (65%) reported no difficulties. However, level of exposure to PTEs was positively associated with number of items that was difficult to answer ($r = 0.34$, $p<0.001$). The qualitative analysis identified three metacategories for why it was difficult to answer: "Event fit", "Me, Victim?", and "You, Perpetrator?". Most prevalent was Event fit; problems in deciding if the personal experience would "fit" the perceived intention of the question. Specifically, informants had difficulties deciding on a dichotomous answer to questions containing dimensional phenomena (such as "serious", "force"). "Me, Victim?" included responsibility, stress reactions, self protection and memory, and "You, Perpetrator?" included intention and protection.

The Myth of Subject Burden: Participants' Reactions to Research Assessment

(Abstract #196270)

Paper Presentation (Asses Dx, Clin Res)

Iverson, Katherine, MA[1]; Resick, Patricia, PhD[1]; Artz, Caroline, BA[1]
[1]National Center for PTSD, VA Boston Healthcare System, Boston, Massachusetts, USA

Institutional review boards and grant reviewers evaluate potential psychological stress or burden that may accompany participation in psychosocial research (Pollick, 2008). However, there is a dearth of empirical examinations of participant distress associated with psychological assessment (Breckler, 2006). The current study provides data regarding participants' reactions to participating in a study examining the efficacy of Cognitive Processing Therapy for PTSD (Resick et al., in press). We present participant responses to a 3- session pretreatment assessment (n = 158), which included interviews, self-report questionnaires, and psychophysiological assessment. Participants rated how distressing and interesting they found each assessment component, as well as their reactions to the length of the assessment and their willingness to be assessed again. Participants reported the diagnostic and trauma interviews and physiological assessment as minimally to moderately distressing and self-report questionnaires as mildly distressing. High levels of willingness to participate in assessments again were also reported. Subject burden, reactions to the length of time required to complete the assessment, was low, with only 9% of the sample rating the assessment as too lengthy. No relationship was found between treatment completion and reported subject burden.

A Four-Factor Structure of the Posttraumatic Diagnostic Scale (PDS): The Addition of Dysphoria

(Abstract #196219)

Paper Presentation (Asses Dx, Cul Div)

Helpman, Liat, MA[1]; Aderka, Idan M., MA[1]; Daie-Gabai, Ayala, MA[1]; Schindel, Inbal, PhD[1]; Foa, Edna, PhD[2]; Gilboa-Schechtman, Eva, PhD[1]

[1]Department of Psychology, Bar Ilan University, Ramat Gan, Israel
[2]University of Pennsylvania, Philadelphia, Pennsylvania, USA

The Posttraumatic Diagnostic Scale (PDS; Foa, Cashman, Jaycox & Perry, 1997) assesses posttraumatic stress disorder (PTSD) symptoms according to *DSM-IV* criteria. The current study examined the factor structure of the Hebrew version of the PDS by means of confirmatory factor analysis in a sample of 378 Israeli adult trauma victims (225 women). The sample included volunteers (N=134), individuals who sought treatment for their children following trauma (N=101), and individuals seeking emergency medical care in a hospital setting (N=143). Participants also completed measures of depression and state anxiety. A series of two-, three- and four-factor models based on previous findings and current *DSM* specification were evaluated. A four-factor model (Intrusions, Avoidance, Dysphoria, and Hyperarousal) based on Simms, Watson and Doebbeling (2002) best fit the data. The Avoidance factor depicted active avoidance from thoughts, feelings and trauma reminders, and the Dysphoria factor included passive avoidance (e.g. numbing) as well as concentration problems, trouble sleeping, and irritability. All factors were significantly associated with measures of depression and state anxiety. It is concluded that the Hebrew version of the PDS is best described by four factors. Results are discussed in the context of the hierarchical models of anxious and depressive affect.

Confirmatory Factor Analysis of PTSD in Female Survivors of Sexual and/or Physical Abuse or Assault

(Abstract #196159)

Paper Presentation (Asses Dx, Res Meth)

Hetzel-Riggin, Melanie, PhD[1]

[1]Psychology, Western Illinois University, Macomb, Illinois, USA

The structure of PTSD has been the subject of debate in recent years. Numerous two-, three-, four-, and five-factor models of PTSD have gained empirical support in studies utilizing exploratory and confirmatory factor analysis. Nine previously tested models of PTSD structure were compared in a large sample (N = 1,061) of female undergraduates who were survivors of sexual and/or physical abuse or assault. A four-factor model of PTSD that included correlated factors of intrusion, avoidance, dysphoria, and hyperarousal exhibited the best fit. The dysphoria factor was also moderately correlated with measures of depression, dissociative symptoms, and general psychological distress, suggesting that this factor may represent general distress found in many clinical disorders. Support for the four-factor dysphoria model may have important treatment and diagnostic implications for clinicians working with survivors with PTSD as well as for future versions of the diagnostic system.

Family Informed Trauma Treatment Model

(Abstract #196075)

Workshop/Case Presentation (Practice, Sos Ethic) **Salon 1, 3rd Floor**

Kiser, Laurel, PhD[1]; Thompson, Elizabeth, PhD[2]; Connors, Kay, LCSW-C[3]

[1]Department of Psychiatry, University of Maryland School of Medicine, Baltimore, Maryland, USA
[2]Kennedy Krieger Institute Family Center, Baltimore, Maryland, USA
[3]Department of Psychiatry, University of Maryland at Baltimore, Baltimore, Maryland, USA

Optimal functioning can be negatively impacted when families experience chronic exposure to trauma(s) and stressors. Contextual risks affect everyone involved, but the effects on children are exaggerated through detrimental influences on parental well-being and family functioning. The Family Informed Trauma Treatment (FITT) Model recognizes and aims to ameliorate the impact of traumatic events and contextual stressors on every member of the family, on family relationships, and on the family as a whole. The FITT Model is multi-layered including: a) explication of the context of chronic trauma/high stress and the multiple pathways through which this context might affect families, b) strategies for identifying and assessing the risk/protective factors and current functioning of family systems, and c) a structured approach for choosing and staging multi-modal, empirically sound treatments targeting the complex needs of traumatized families. The FITT Model indicates trauma specific, help seeking pathways to treatments that reduce PTSD symptoms, promote safety and recovery for all family members. This model provides the framework for an ecological family systems intervention approach that aims to tackle obstacles that derail families´ efforts to attain safety and stability by putting families in the "driver´s seat" as they plot a course to address their unique needs.

How to Succeed in Publishing as a Student

(Abstract #196342)

Workshop/Case Presentation (Media Ed, Res Meth) **Salon 2, 3rd Floor**

***Legerski, Joanna, MA*[1]; Geffner, Robert, PhD[2]; Schnurr, Paula, PhD[3]; Taft, Casey, PhD[4]; La Bash, Heidi, BS[5]**

[1]University of Montana, Missoula, Montana, USA
[2]Family Violence and Sexual Assault Institute, San Diego, California, USA
[3]National Center for PTSD, VA Medical Center, White River Junction, Vermont, USA
[4]VA Boston Healthcare System, Boston, Massachusetts, USA
[5]University of Nevada, Reno, Nevada, USA

Four clinical researchers who have participated on editorial boards, present information regarding the process of successfully submitting scholarly articles for publication. Students of ISTSS have continued to request training at annual meetings related to the process of submitting scholarly work for publication within the field of traumatic stress. This student focused workshop will address key components of achieving success in publication.

The workshop will approach the process of publication with regard to four key topics:

1. Key features of successful article submission
2. How to strengthen your article for statistical review
3. How to avoid procrastination; begin and COMPLETE the writing process
4. How to develop collaborations and find publishing opportunities as a student

Psychological Effects of Long-Term Deployment on Children of Military Personnel

(Abstract #196501)

Workshop/Case Presentation (Practice, Child) **Salon 3, 3rd Floor**

Findeis, Lori, MSW, LCSW[1]; Findeis, Michael, MS[1]
[1]College of Social Work, University of Utah & Children's Counseling Center, Orem, Utah, USA

It is estimated that over 700,000 children have at least one parent who is deployed. Families of these military personnel have been left to deal with the impact of 6-12 month deployments, as well as multiple deployments in short periods of time. Children not accustomed to one (or both) parents being deployed for significant periods of time have reported more intense symptoms of stress-related behaviors in increased mental health concerns.

The Children's Counseling Center in Orem, Utah has seen a dramatic increase in the number of cases of children being referred for counseling from these military families. Children of military personnel deployed appear more angry, emotionally detached, appear more emotionally disorganized and disoriented.

The purpose of this presentation is to present case studies that illustrate the unique psychological effects facing the children of deployed military personnel. Four phases of deployment will be discussed (pre-deployment, deployment, reunion and post-deployment), along with specific behaviors and emotional conditions that children experience in each of these phases.

This presentation will identify from case studies, salient clinical issues and discuss treatment approaches that have been found most effective in minimizing the impact of prolonged deployment for children of military personnel in an outpatient mental setting.

Participant Alert: Some individuals may find the descriptions of clinical case studies disturbing.

Treating Trauma-Related Sleep Problems: An Evidenced-Based Cognitive Behavioral Approach

(Abstract #196531)

Workshop/Case Presentation (Practice, Clin Res) **Salons 4-6, 3rd Floor**

Zayfert, Claudia, PhD[1]; DeViva, Jason, PhD[2]
[1]Dartmouth College, Lebanon, New Hampshire, USA
[2]Newington VAMC, Newington, Connecticut, USA

Difficulty falling and staying asleep is one of the most common clinical complaints after a traumatic event. Trauma-related insomnia is associated with fatigue, daytime sleepiness, irritability, and worsening of overall health and functioning. Treatment of sleep difficulties related to trauma is, therefore, important to the clinical aim of reducing overall distress of trauma survivors. In this workshop clinicians will learn how to address the various factors that precipitate and maintain sleep problems following traumatic experiences. We will present a model for understanding the initiation and maintenance of sleep problems, integrating predisposing, precipitating, and perpetuating factors that contribute to trauma-related insomnia. Participants will then learn to systematically address the factors contributing to trauma-related insomnia using well-researched effective cognitive behavioral methods for treating precipitating factors (i.e., nightmares and vigilance) and perpetuating patterns of behavior and cognition. This will include detailing the basic components of cognitive behavioral treatment for insomnia and using extensive case material to demonstrate tailoring application of these components to address the specific manifestations of insomnia among survivors of trauma. Factors affecting sleep of returning military personnel will be specifically addressed.

Concurrent Session 12
Saturday, November 15
11:00 a.m. – 12:15 p.m.

News Media and Trauma – Candid Views From Australian Journalists

(Abstract #196415)

Media Presentation — **Salons 4-6, 3rd Floor**

Millar, Lisa, BA[1]; **McMahon, Cait, MS**[2]; ***Newman, Elana, PhD***[3]; **Spratt, Margaret, PhD**[4]
[1]*News, Australian Broadcast Corporation, Sydney, New South Wales, Australia*
[2]*Dart Centre for Journalism and Trauma, Brighton, Victoria, Australia*
[3]*Psychology, University of Tulsa, Tulsa, Oklahoma, USA*
[4]*Dart Center / Dept. of Communication, University of Washington, Seattle, Washington, USA*

"News Media and Trauma," produced by Brett McLeod of Channel Nine with support from Dart Centre Australasia, presents a series of interviews with Australian journalists sharing their experiences of reporting horror and tragedy. "Across the industry there´s some common understanding of what needs to be done in terms of preparing people to do this sort of work," McLeod explains. "But it´s not often enunciated by experienced staff nor by newer journalists, probably for fear of being seen by their peers as `too soft.' This DVD is not about 'soft' journalism. It's about doing the job professionally and turning out a better product without harming ourselves or others."

The purpose of the DVD is as a preventative training tool for student and cadet journalists. However, it is also effective as a discussion starter about the issue of trauma exposure on working media professionals. "News Media and Trauma" is intended to accompany a training program about trauma awareness, self care and duty of care.

Perspectives on Internship, Post-Doc & Residency: Getting the Most Out of Your Experience

(Abstract #196021)

Symposium/Panel (Media Ed, Practice) — **Salon 2, 3rd Floor**

Averill, Lynnette, PhD CANDIDATE, MS[1]; **Batten, Sonja, PhD**[2]; **Sedlar, Georganna R., PhD**[3]; **Frank, Julia, MD**[4]; **Moore, Sally A., PhD**[5]
[1]*University of Utah, Salt Lake City, Utah, USA*
[2]*Maryland VA Health Care System, Baltimore, Maryland, USA*
[3]*Department of Pediatrics, University of California Davis Medical Center, Sacramento, California, USA*
[4]*George Washington University, Washington, District of Columbia, USA*
[5]*Puget Sound VA Medical Center, Seattle, Washington, USA*

This panel is hosted by the ISTSS Student Section and is intended to give students an opportunity to hear perspectives regarding internship, post-doc and residency opportunities for trauma focused training sites. Two training directors, one selection committee member/clinical supervisor and one recent intern will discuss how to get the most out of your training experience. They will discuss the key factors to consider when choosing training sites, how to rank these sites, what sites look for in their applicants, what to include in essays and cover letters and other useful information. There will be a question and answer period.

Optimizing Survey and Experimental Methods in PTSD Prevention Trials

(Abstract #196104)

Symposium/Panel (Clin Res, Res Meth) — **Monroe Ballroom, 6th Floor**

Zatzick, Douglas, MD[1]; **Shalev, Arieh, MD**[2]; **O'Donnell, Meaghan, PhD**[3]; ***Galea, Sandro, MD, MPH, DRPH***[4]
[1]*University of Washington, Seattle, Washington, USA*
[2]*Psychiatry, Hadassah University Hospital, Jerusalem, Israel*
[3]*Psychiatry, University of Melbourne, Melbourne, Victoria, Australia*
[4]*University of Michigan, Ann Arbor, Michigan, USA*

Recent innovations in early PTSD prevention trials include the integration of survey methods with more traditional experimental designs. In this panel discussion three brief presentations will highlight these innovative methods. Following the presentations discussant led audience participation will be encouraged.

Survey and Experimental Methods in PTSD Prevention Trials: The Jerusalem Trauma Outreach and Prevention Study (J-TOPS)
Arieh Y. Shalev, MD, will be presenting on: Responding to urgent needs in the Israeli, and particularly the Jerusalemite communities, J-TOPS was designed to answer questions regarding the efficacy and the effectiveness of three early interventions (CBT, cognitive therapy, and an SSRI/placebo condition) and one delayed intervention (CBT) in preventing PTSD. The study consists of equipoise randomized controlled trial (n=289) embedded in a two layers´ survey: clinical assessment (initial n=753) and telephone assessment (initial n=1983+200). Several problems related to combining survey and clinical trials methods have emerged: A measurement problem (do we measure the same entity by the two methods), a problem of timing (difference between measurements performed at close – but not identical time points), and a problem of acceptance and accuracy of responses (particularly between self administered and clinician generated measures). The magnitude of these problems and their effect on outcome are the subject of this presentation.

Early Psychological Intervention Following Traumatic Injury: An Effectiveness Trial
Severe injury represents one of the most frequent causes of posttraumatic stress disorder and other posttraumatic reactions such as depression and anxiety. We will present a unique effectiveness trial that aimed to address posttraumatic mental health problems following traumatic injury (trail will be completed in September 2008). The early intervention model being tested screened individuals at high risk for PTSD and depression following injury (n>700) during their acute hospitalization, monitored those who screened high risk (n>330), and then selectively targeted psychological intervention to individuals with persistent traumatic stress symptoms. Approximately 50 symptomatic patients were randomly allocated to early psychological intervention or usual care conditions. We will present whether there were significant group differences in anxiety and depression symptoms between those in each treatment condition. We will also discuss methodological issues relevant to effectiveness trials such as the use of flexible treatment manuals, barriers to care and the management of complex cases.

Elucidating a Reciprocal Relationship Between Effect Size and Intervention Reach in Early PTSD Prevention Trials
Randomized clinical trial (RCT) design often involves choosing between two competing aims: (1) estimating efficacy in highly selected patients conditions; and (2) estimating its effectiveness in the full target population of potential recipients. We aimed to develop an approach to quantifying the efficacy/effectiveness continuum through the integration of clinical epidemiologic survey methods into the design of two RCTs targeting PTSD prevention after injury. Utilizing trauma registry data we first specified and then contrasted the target populations represented by participants in one efficacy trial (Wagner et al 2007) and one effectiveness trial (Zatzick et al 2004). Patient clinical and demographic characteristics

were compared, as were indices of efficacy (effect size) and target population generalizability (reach). In these two trials, there was a reciprocal relationship between effect size and reach, such that the efficacy trial demonstrated a larger effect size (Cohen´s h = 0.60) but minimal reach (1%), while the effectiveness trial demonstrated a smaller effect size (Cohen´s h=0.07) but greater reach (54%). Modeling of the potential population impact of the two trials suggested a greater cumulative reduction in the incidence of PTSD would result from dissemination of the effectiveness prevention strategy.

Recent Developments in Mild Traumatic Brain Injury

(Abstract #196133)

Symposium/Panel (Asses Dx, Practice) **Adams Ballroom, 6th Floor**

Iverson, Grant, PhD[1]; Kenardy, Justin, PhD[2]; Hoge, Charles, MD[3]; Bryant, Richard, PhD[4]
[1]Department of Psychiatry, University of British Columbia, Vancouver, British Columbia, Canada
[2]Department of Psychology, University of Queensland, Herston, Queensland, Australia
[3]Division of Psychiatry and Neuroscience, Walter Reed Army Institute of Research, Silver Spring, Maryland, USA
[4]School of Psychology, University of New South Wales, New South Wales, New South Wales, Australia

Recent events in Iraq and Afghanistan have focused renewed attenton on the problems associated with mild traumatic brain injury (MTBI). This symposium will present four papers reporting very recent data on large sample sets of children and adults with MTBI. The studies from three different countries focus on the critical issues of methodological issues concerning assessment of MTBI, predictors of problems following MTBI in children and adults, the utility of screening for MTBI, and the interaction between MTBI and PTSD. These studies represent the latest developments in the field and provide unique data to address the key questions challenging the field of MTBI and adaptation after trauma. Importantly, because these studies focus on MTBI and psychological factors in children, civilian adults, and military personnel, the symposium will allow inferences concerning the generalizability of these findings across populations.

Methodology Matters: Reducing Risk for Misdiagnosing the Persistent Post-Concussion Syndrome
Research is needed to improve diagnostic accuracy for the persistent post-concussion syndrome. We present a series of analyses illustrating methodological factors that can potentially worsen diagnostic accuracy. Participants were consecutive referrals to a concussion clinic over a 2-year period. All participated in semi-structured interviewing and completed questionnaires, and a subset completed neuropsychological screening. Three important findings emerged. First, patients perceived themselves as having fewer post-concussion-like symptoms and problems prior to getting injured compared to healthy control subjects. Previous researchers have called this phenomenon the "good old days" bias. Second, patients reported far more symptoms when given a questionnaire than they did through careful semi-structured interviewing. Thus, patients will be much more likely to meet diagnostic criteria for a persistent post-concussion syndrome based on questionnaire results as opposed to interview results. Third, it was relatively common for patients to fail effort testing. Those who failed reported more post-concussion symptoms than those who passed. These factors could affect the clinician´s understanding of the patient´s functioning and potentially affect diagnosis decisions.

Predictors of Health Functioning at 12 Months Post-Injury in Children With Traumatic Brain Injury
The aim of this paper is to explore the predictive value of a range of injury, pre-injury variables and post-injury traumatic stress in identifying functioning outcomes in children with Traumatic Brain Injury (TBI) at 12 months post-injury. 204 children aged 6-14 years and their parents were recruited following admission at emergency departments for TBI. Participants were assessed at several time points post-injury. Predictor variables include injury severity, pre-injury functioning, and 3-month Posttraumatic Stress (CAPS-CA). Initial analyses indicated that TBI severity (mild, moderate, severe) did not predict children´s physical functioning at twelve months post injury (p = .31). However, injury severity was found to predict children´s psychosocial functioning (p < .005). PTSD significantly predicts psychosocial functioning independently of TBI severity (p<.005), furthermore the prediction of health outcomes by the severity of TBI is moderated by the presence of PTSD. Finally the independent contribution of PTSD symptom levels significantly improve prediction of health outcomes at 12 months.

Conclusion: Early identification of PTSD in children who have potential long-term problems from traumatic brain injuries will assist clinicians to target services and assess the needs of these children and their families to assist in rehabilitation and recovery following TBI.

Mild Traumatic Brain Injury and Post-Concussive Symptoms Among Veterans of the Wars in Iraq and Afghanistan: What Would Sir Bradford Hill Have to Say?
Mild traumatic brain injury (mTBI) has been labeled a "signature" injury of the current wars in Iraq and Afghanistan, based on reports that as many as 15-20% of troops have suffered a mild TBI, often in association with exposure to blast explosions. This has led to population-level screening for mTBI and other efforts by DoD and VA to identify and mitigate the health effects attributed to mTBI. However, because of limited evidence-based studies to guide public health policy, these efforts have been developed largely on the basis of consensus and expert opinion. This talk will examine the interface between evidence and clinical lore for mTBI, drawing on civilian literature as well as recent data collected among returning veterans from Iraq and Afghanistan. topics that will be discussed include the case definitions and prevalence of mTBI and post-concussive symptoms among returning veterans, the "overlap" between mTBI and PTSD, the assumptions underlying current screening efforts, and recommended best practices for the evaluation and treatment of mTBI and post-concussion symptoms among combat veterans. The study will examine these topics within the framework of the principles of epidemiological causation outlined originally by Sir Bradford Hill.

Mild Traumatic Brain Injury and Psychiatric Disorder
There is much controversy concerning the impairment caused by mild traumatic brain injury (MTBI). Although many patients with MTBI suffer impairment, there is little understanding of the causes of this impairment. 1126 traumatically injured patients were assessed during hospital admission to 5 tertiary trauma centers for lifetime psychiatric disorder. Patients were followed-up at 3 months (n = 990) and 12 months (n = 868) after injury to assess for current psychiatric disorder, quality of life, and mental health service use. 478 (43%) patients sustained a MTBI. Twelve months after the injury, 23% of patients had developed a psychiatric disorder that was never present before the injury. The most common psychiatric disorders were depression (12%), generalized anxiety disorder (9%), PTSD (7%), and agoraphobia (7%). Patients were more likely to develop posttraumatic stress disorder PTSD (OR: 1.97, 95% CI: 1.09-3.52) or a substance use disorder (OR: 2.30, 95% CI: 0.74-7.14) if they had sustained a MTBI. Functional impairment was associated with psychiatric disorder rather than MTBI. A significant range of psychiatric disorders occur after traumatic injury. MTBI is associated with marked functional impairment when it is accompanied by psychiatric disorder. The identification and treatment of psychiatric disorder is important in the recovery after traumatic injury.

ISTSS at the UN & the 60th Anniversary of the Universal Declaration of Human Rights

(Abstract #196207)

Symposium/Panel (Cul Div, Sos Ethic) **Salons 7-9, 3rd Floor**

Danieli, Yael, PhD[1]; Carll, Elizabeth, PhD[2]; Braak, Joyce, MD[3]; Turner, Stuart, MD, MA, FRCP, FRCPsych[4]

[1]ISTSS Representative to the United Nations, New York, New York, USA
[2]ISTSS Representative to the United Nations, Centerport, New York, USA
[3]ISTSS Representative to the Untied Nations, Catskill, New York, USA
[4]Trauma Clinic, London, United Kingdom

ISTSS works through its representatives to the United Nations who strive to expand the reach of our efforts to increase international awareness of Traumatic Stress and the organization by varied means, such as creative collaborations.

Do Rights Reach Victim/Survivors?
Rather than merely reviewing existing human rights, Yael Danieli, PhD, will examine whether and how they reach the victims. She will present both negative and positive situations, and lessons learned from them. Examples will include the impact of the initial lack of outreach and follow up of the international Criminal tribunals of the former Yugoslavia and of Rwanda as they have influenced latter practices for them, and for developing improved measures for the International Criminal Court in general and the ICC Trust Fund for Victims in particular.

Media/ICT, Human Rights, and Social Change
The media plays an essential role not only in the dissemination of information to the public, but also in its ability to influence social change. Violence, war, genocide, and disasters are reported daily in the news. Also emerging is the recognition of media´s potential in highlighting human rights abuses and laying a foundation for building peace. This presentation will examine a variety of media initiatives, including both traditional and new media, to prevent violence against women, children, and communities and promote well-being. These emerging trends will be discussed in context of the 60th anniversary of the Declaration of Human Rights and the right to peace and security for all.

ISTSS Collaboration Work With UN Bodies, NGOs, and Committees
The 60th Anniversary of the Universal Declaration of Human Rights is woven through a whole year of UN activities. Positions held in UN NGO Committees, while very demanding of time and work, also offer the opportunity for collaborations that permit the inclusion of trauma in many areas of UN official work. These collaborations open space for increased awareness of the traumatic stress inherent in violations of human rights and expanded visibility of ISTSS, and influence international policy decisions. This presentation will provide examples of the ways an NGO representative can creatively work in Committees, with other NGOs and with UN Missions of member states, and with UN bodies. These collaborations and cooperations expand the work and influence of ISTSS into international awareness and policies.

While much of this work depends on developing relationships and remains below public visibility and attribution, the impact of this work is remarkably powerful. This presentation will provide attendees a behind the scenes look at how the work of ISTSS is done in creative collaborations around Human Rights and Trauma at the UN.

Transformation of Trauma Through Media

(Abstract #196214)

Symposium/Panel (Disaster, Sos Ethic) **Wabash Room, 3rd Floor**

McFarlane, Alexander, MBBS, MD, DIP.PSYCHOTHER., FRANZCP[1]; Pynoos, Robert, H.S.D, BA, MPH, MD[2]; Weisaeth, Lars, MD[3]

[1]Centre for Military & Veterans' Health, University of Adelaide, Adelaide, South Australia, Australia
[2]UCLA, National Center for Child Traumatic Stress, Los Angeles, California, USA
[3]Norwegian Centre for Violence and Traumatic Stress Studies, Ullevål University Hospital, Oslo, Norway

This presentation will examine the way in which fear, trauma and war have been reflected and transformed through different media in the course of history. This will include a spectrum of literature, oral history and art as well as photography. Specific examples will be used to explore the themes of transformation.

Transformation of Trauma Through Art & Literature
Trauma, by its nature confronts individuals and groups with overwhelming experiences which are difficult to integrate with the past, present and future. Major events such as wars and disasters transforms societies in ways that are difficult to predict. The development of images and rituals that allow the transformation and integration of traumatic experiences represent important transition points that allow healing and development of new forms of symbolic language. This presentation will focus on how a number of the great novelists of the 20th Century have served to grapple with the reality of war in ways that have built a bridge for veterans returning to civilian life. Further, the nature of art has been irreparably transformed by the development of the camera which provides real images allowing painting to explore in more symbolic and abstract forms, the fragmentation of awareness which trauma presents.

Historical Chronology of Danger, Trauma & Terror
This presentation will examine the depiction of danger, trauma and terror in historical chronology by use of oral history, the written word, master paintings, printmaking, photography, modern art, film, and the internet. It will begin with the earliest recorded autobiographical account by an adolescent of catastrophic disaster, the letters by Pliny the Younger of the eruption of Mt. Vesuveus in 70 A.D. It will then include Macchiavelli´s The Prince as a political ideology born out of torture, master paintings through the centuries depicting disaster/war, the use of printmaking, for example, Goya's Disaster of War, the world wide impact of photography from the U.S. Civil War, including Manet and his famous Death of a Matador, the World War I artists, for example, Otto Dix, the strong influence of WWI on early horror movies, the masterpiece by Picasso, Guernica (depicting the trauma and horror of civilian air attacks), and the current use of the internet to send images all over the world immediately in the aftermath of disaster, a terrorist attack, or a campus shooting.

Edvard Munch—Pioneer Psychotraumatologist?
In 1868 a Norwegian military doctor lost his wife in tuberculosis and was left with five small children. Sofie, his smallest daughter died a few years later of the same disease and one of his sons later also died. Such tragedies were not rare at that time. Why should this family then provide us with more insight into loss, grief, love and anxiety than perhaps no other family, with the obvious exception for the Holy family?

When Edvard Munch painted Sick Girl, and at the same time wrote down his recollections from that moment when his sister Sofie died, he made two discoveries: That lost family members came alive and that by facing the trauma he could cope with it. He understood that the bereavement process should not lead to a rupture in the relationship with the deceased, but to an altered relationship.

Edvard Munch´s willingness to re-expose himself to his traumatic memories and the way he did it seem to represent an early discovery of important therapeutic interventions that helped him cope with his traumas. It also helped give birth to expressionism in art.

Trauma and Self: Culture, Identity, and Cognitive Predictors of Depressive and PTSD Symptoms

(Abstract #196345)

Symposium/Panel (Clin Res, Practice) **State Ballroom, 4th Floor**

DePrince, Anne, PhD[1]; Klest, Bridget, BENG, MA[2]; Freyd, Jennifer, PhD[2]; Hampson, Sarah, PhD[3]; Goldberg, Lew, PhD[4]; Hebenstreit, Claire, BA[1]; Combs, Melody, MA[1]; Chu, Ann, MA[5]; Kaysen, Debra, PhD[6]; Lee, Christine, PhD[6]; Kilmer, Jason, PhD[7]; Nobles, Richard, MS[8]; Neighbors, Clayton, PhD[6]; Pineda, Annarheen, MA[1]

[1]Psychology, University of Denver, Denver, Colorado, USA
[2]University of Oregon, Eugene, Oregon, USA
[3]University of Surrey, Guildford, United Kingdom
[4]Psychology, University of Oregon, Eugene, Oregon, USA
[5]University of Denver, Denver, Colorado, USA
[6]University of Washington, Seattle, Washington, USA
[7]Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, Washington, USA
[8]Department of Psychology, University of Washington, Seattle, Washington, USA

Trauma has been associated with changes in beliefs about the self and others, as reflected in the criteria for depression and PTSD. Panelists will describe data from diverse samples that evaluate the contributions of culture, identity, appraisal, and neuropsychological factors in the development of depressive and PTSD symptoms.

Trauma, Personality, and Demographic Predictors of Depression
Past research indicates that traumatic events in early life predict depression in adulthood. A number of other personal characteristics, such as personality style and socio-demographic group, have been implicated as risk factors for both trauma exposure and experiencing depression. This study examines the interplay between trauma, gender, culture, and personality in the prediction of depressive symptoms. Six-hundred seventy-nine ethnically diverse participants were rated on personality characteristics as children, and were later surveyed in adulthood for experiences of trauma and symptoms of depression. In this sample, childhood personality was related to trauma exposure in adolescence and adulthood, which in turn was related to depressive symptoms. However, gender and culture were related to trauma exposure, personality characteristics, and depression, complicating interpretation of these results. The relative contributions of each of these factors and interactions among factors in predicting depression are discussed. In addition, the implications for prevention and treatment of depression are explored.

Examining Links Between Violence Exposure, Depression, and Executive Function
Revictimization is associated with a range of deleterious consequences, including higher levels of depressive symptoms. to date, little research has considered the neuropsychological correlates of repeated violence exposure. The current study considers links between revictimization, depression, and executive functions (EFs). EFs include a range of cognitive skills involving attention, working memory, self-monitoring, and generation of hypotheses. A significant body of research documents EF deficits among depressed individuals. Given reciprocal relations between brain regions that control EFs and emotional regulation systems, associations between emotional wellbeing and EF are not surprising; however, these associations have been understudied in violence-exposed populations. The current study involved an ethnically diverse community sample of 93 women (Age: Mean 30.1, SD 6.2) who completed a battery EF tasks that assessed processing speed, working memory, inhibitory control, and selective attention. They reported an average of 5.8 violent events, and 5.3 different perpetrators. The number of events and perpetrators were both significantly related to depressive symptoms, revealing large and medium effect sizes. We will discuss the role of EF abilities in explaining links between violence exposure and depressive symptoms, with an emphasis on implications for treatment.

An Examination of Trauma Exposure, PTSD Symptoms and Substance Use in Sexual Minority College Students
Lesbian, gay, and bisexual (LGB) youth are at higher risk for trauma exposure and substance misuse. However, less is understood about mental health outcomes following trauma exposure in this population. Our goals were to evaluate 1) sexual minority status and PTSD symptom severity; 2) trauma exposure and increased alcohol use and consequences and higher marijuana use within GLBT students; and 3) whether trauma exposure and outcomes are moderated by identification with other college students. The sample included 3748 (58.3% female) college students. 134 students identified as GLBT. Students completed the Posttraumatic Stress Diagnostic Scale (PDS) and measures of alcohol and marijuana use and consequences. PTSD was predicted by gender, trauma exposure, sexual minority status, alcohol use and consequences. GLBT trauma survivors had higher marijuana use, although there were no differences in drinking. GLBT students were less likely to identify with the "typical college student". Among GLBT students, both trauma exposure and PTSD symptoms were associated with lower identification with the "typical college student". Results suggest GLBT youth may be at risk for negative health outcomes following traumatic events. We will discuss potential theoretical mechanisms to explain these risk factors and treatment implications.

Appraisals of Self and Others in Relation to Posttraumatic Distress in Young Adults
Research and clinical work has long demonstrated the importance of posttraumatic appraisals (e.g., betrayal, anger, shame) to understanding diverse mental health outcomes. While fear, helplessness, and horror have received significant attention given their inclusion in Criterion A, the current study considers appraisals of self and self in relation to others. In particular, we will examine links between violence exposure and posttraumatic appraisals of betrayal, shame, self-blame and alienation. Beliefs about being alienated from others have received scarce attention in the literature, though negative interpersonal consequences of violence and trauma are common. The current study examined trauma exposure, posttraumatic symptoms, and appraisals in a sample of 109 undergraduate volunteers (20.3; 76% female). We found links between revictimization (relative to single victimization) and posttraumatic symptoms. Alienation appraisals explained unique variance in posttraumatic stress disorder symptoms when controlling for trauma exposure and other appraisals (e.g., shame, self-blame). We will discuss the implications of these findings from a developmental perspective in light of the interpersonal tasks emerging adults face. In addition, we will discuss implications for treatment.

Posttraumatic Stress, Maternal Health and Pregnancy Outcomes

(Abstract #196358)

Symposium/Panel (Clin Res, Bio Med) **Grand Ballroom, 4th Floor**

Charvat, Mylea, MS[1]; Yehuda, Rachel, PhD[2]; Morland, Leslie A., PhD[3]; Hogan, Lindsey, BA[4]

[1]Pacific Graduate School & Veterans Health Care System, San Francisco, California, USA
[2]Division of Traumatic Stress Studies, Mount Sinai School of Medicine, and PTSD program Bronx Veterans Affairs, Bronx, New York, USA
[3]Psychiatry, University of Hawaii, Honolulu, Hawaii, USA
[4]Pacific Graduate School of Psychology, Palo Alto, California, USA

Posttraumatic stress disorder among women of childbearing age will be discussed in terms of the implications of the behavioral, physical health and neuroendocrine changes commonly associated with PTSD and how those changes may affect health outcomes for mothers and infants.

Trauma in the Womb: Biological Mechanisms for Transmission of Maternal Trauma and PTSD to Offspring
Rachel Yehuda, PhD Division of Traumatic Stress Studies, Mount Sinai School of Medicine, and PTSD program Bronx Veterans Affairs.

Description: It has been recognized for some time that exposure to stress and/or other environmental challenges (such as starvation) during pregnancy can have longlasting effects on the fetus. The most notorious of these effects is low birh weight, which increases the risk for adult cardiometabolic disease. The mechanism underlying these outcomes is now understood, and seems to involve changes in the expression of an enzyme, that increases in activity in the middle of the second trimester of pregnancy. This enzyme—11 beta hydroxysteroid dehydrogenase - type 2 (11-bHSD) —converts active cortisol to inactive cortisone, thus acting as a "placental barrier" to shield the fetus from exposure to toxic levels of cortisol. But high levels of stress can "program" the activity of this enzyme in developing fetus, leading to permanent changes in the hypothalamic-pituitary-adrenal (HPA) axis. This presentation will discuss recent data about this enzyme in offspring whose mothers were exposed to trauma while pregnanat. Interestingly, the changes in activity of 11-b-HSD-2 are in the direction that explain enhanced glucocorticoid responsiveness and low cortisol levels in PTSD.

A Sequential Examination of Posttraumatic Stress Across the Gestational Period Including Postpartum
Posttraumatic stress disorder (PTSD) is pervasive among women of childbearing age. The cascade of behavioral health and neuroendocrine changes commonly associated with PTSD may adversely impact perinatal health. To date little is known about how posttraumatic stress symptomotology may change over the course of the perinatal experience.

Methods: This study sequentially examined PTSD symptoms at different time points during pregnancy and postpartum in a sample of 101 women receiving prenatal care on the island of Oahu, Hawaii. Trauma, PTSD, and psychological and behavioral health were assessed during the first, second and third trimesters and at 6 weeks postpartum. We are building a dynamic structural equation models that will then be tested using Mplus. Findings will be discussed in the context of clinical and research implications.

Trauma and Prenatal and Perinatal Care: The Relationship Between Postraumatic Stress and Women's Health Care Choices During the Prenatal and Perinatal Time Periods
Posttraumatic stress disorder is prevalent among women of childbearing age. The patterns of behavioral and health changes associated with posttraumatic Stress may affect women´s health utilization behavior and health decision making process regarding prenatal and perinatal care. At present little is known about the relationship between posttraumatic stress and women´s prenatal and perinatal health care patterns. This study examined a sample of 94 women who had given birth in the past 3 years. Trauma, PTSD, psychological health, prenatal and perinatal care (including infant feeding method) were assessed. This presentation will discuss the relationship between posttraumatic stress and prenatal care and infant feeding patterns among the mothers. Findings will be discussed in the context of implications for clinical work and future research.

HPA Axis Evidence of Transgenerational Effects of Maternal Early-Life Trauma in 6-Month-Old Infants

(Abstract #196208)

Paper Presentation (Child, Bio Med) **Grand Ballroom, 4th Floor**

Brand, Sarah, MA[1]; Brennan, Patricia, PhD[1]; Newport, Jeffery, MD[1]; Smith, Alicia, PhD[1]; Stowe, Zachary, MD[1]
[1]Emory University, Atlanta, Georgia, USA

Previous research suggests that parental PTSD may have a transgenerational impact, with offspring of trauma survivors showing similar neuroendocrine profiles as their parents. The majority of these studies focus on adult offspring, and the degree to which the effects of parental trauma can be detected earlier in the development of the offspring remains obscure. The current study examines a clinical sample of women with a history of major depression (N= 108), who participated in a prospective, longitudinal investigation of the impact of maternal depression on infant HPA-axis function at 6 months. Specifically, we examine the effects of maternal early life sexual and physical abuse (Childhood Trauma Questionnaire; CTQ) on both maternal and infant salivary cortisol levels during a laboratory stress paradigm. Preliminary analyses suggest that positive maternal trauma history was associated with lower cortisol reactivity in the mothers, as well as lower baseline cortisol in their infants. Of note, comorbid maternal PTSD was a significant moderator, such that maternal trauma history was associated with higher cortisol reactivity in infants and mothers when comorbid maternal PTSD was present. These data suggest that a maternal history of trauma may influence infant HPA-axis activity at 6 months of age.

Impact of Catastrophic Events on First Responders and Children

(Abstract #196446)

Symposium/Panel (Disaster, Child) **Salon 1, 3rd Floor**

***Brymer, Melissa, PhD, PsyD*[1]; Osofsky, Howard, MD, PhD[2]; Osawa, Tomoko, PhD[3]; Kato, Hiroshi, MD, PhD[3]; Osofsky, Joy, PhD[4]**
[1]National Center for Child Traumatic Stress, UCLA, Los Angeles, California, USA
[2]Dept of Psychiatry, Louisiana State University Health Science Center, New Orleans, Louisiana, USA
[3]Hyogo Institute for Traumatic Stress, Chuo-ku, Kobe, Japan
[4]Psychiatry and Psychiatry Departments, Lousiana State University Health Sciences Center, New Orleans, Louisiana, USA

This workshop will focus on how first responders and children are impacted by such catastrophic events such as hurricanes, earthquakes, and school shootings. The presenters will also highlight the feasibility of conducting screenings and assessments and the importance of providing long-term mental health services to these affected populations.

Impact of Hurricane Katrina on First Responders
About 80% of New Orleans first responders lost their homes, and many were separated from their families for long periods of time. A study was conducted of nearly 600 first responders (police, firefighers, and EMTs) between February and May 2006 using the PTSD Checklist-Civilian Version and the Center for Epidemiologic Studies Depression Scale-Short Form. The surveys also included questions about alcohol use and the quality of marital relationships. More than 95% of the first responders participated in the survey. The findings showed that many first responders witnessed deaths and injuries, and one in 20 reported the death of a family member. While resilient and hard-working, many first responders reported personal and mental health difficulties. Ten percent reported symptoms of PTSD and nearly 25% reported symptoms of depression. Forty percent reported an increase in alcohol consumption and 41% reported an increase in marital conflict. Forty percent of first responders indicated the need for mental health services for themselves and their families. The

implications of these findings and how they influenced services in the field will be highlighted.

The Long-Term Impact of the Kobe Earthquake and a Susequent Traumatic Accident on Firefighters
This presentation will focus on a study that looked at the long-term psychological impact among fire fighters (N=1432) who experienced the 1995 Kobe Earthquake and who lost four members in the line of duty in 2003. Among those who were members at the time of earthquake, 11.6% were at high risk for PTSD nearly 10 years after the disaster. Those that reported experiencing danger to one´s life; saw grotesque scenes; felt fearful, helplessness, and or guilt; increased stress in their family life; and did not know of the safety of one´s family members had significantly high IES-R scores than those who did not. As for the effects from the tragic incident in which fellow firefighters were killed in the line of duty, 6.4% of participants were at high risk for PTSD based on the IES-R. When examining those firefighters who were at the accident site and witnessed the death of their colleagues, the ratio of high risk increased to 14.4%. Approximately 10% of the participants were at risk for depression and anxiety symptoms measured by K10. This figure is about two times higher than general population epidemiology studies. This presentation will highlight the needs for comprehensive mental health services for firefighters that go beyond acute interventions.

Impact of Hurricane Katrina on Children
This presentation will highlight the risk and protective factors contributing to children and adolescents´ psychological reactions following the devastation caused by Hurricane Katrina and the subsequent flooding in New Orleans. Participants included children in grades 4-12 attending schools in heavily impacted parishes. The National Child Traumatic Stress Network Hurricane Assessment and Referral tool for Children and Adolescents was administered in collaboration with school districts. A total of 7,258 students completed the referral tool. In 2005-2006, 49% of the students met cut-off for needing mental health services. This was consistent in 2006-2007, when 41.6% of the students met cut-off for needing mental health services. While children and families in general are resilient, mental health symptoms are common and persistent and show the need for long-term clinical services. Consistent with other disaster literature, experience of prior trauma, property loss, separation from caregiver, significant personal losses, and living in a shelter were predictors of symptomatology. Implications on how these findings can guide more effective ways to prepare and support children and families when future disasters occur will be discussed.

The Psychological Impact of a School Shooting on High School Students
This presentation will focus on a study that examined the psychological sequelae among high school students exposed to a tragic high school shooting at Santana High School. The study used a dose-of-exposure design to determine the severity of posttraumatic stress and depressive reactions of 1,160 adolescents 8 to 9 months after the shooting. Additional measures included demographic information, objective and subjective exposure, and relationship with those killed, those injured, and with the shooter. The findings revealed that students reported high rates of PTSD, especially those in the Direct Exposure Group, as compared to epidemiological studies. Findings showed a dose-of-exposure pattern for PTSD but not for depression. Girls scored higher than boys on both distress measures. Subjective features of exposure played a powerful explanatory role in predicting the variance in PTSD and less so for depression. Of importance, this study utilized an innovative subjective features of exposure scale geared to the students´ appraisal of threat and harm. This study demonstrates the feasibility of conducting systematic school-wide screening after a school shooting, and provides guidelines for services after such events occur.

Companion Recovery Model Reduces the Effects of Trauma for Male and Female Child Soldiers in Liberia

(Abstract #195965)

Workshop/Case Presentation (Clin Res, Civil Ref) **Salon 3, 3rd Floor**

Gregory, Jeni, PhD[1]; Embrey, David G., PhD[2]
[1]Vice President, World Change for Children, University Place, Washington, USA
[2]Childrens Therapy Unit, Good Samaritan Hospital, Puyallup, Washington, USA

Purpose: This workshop describes a Companion Recovery Model, designed to reduce the symptoms of PTSD in former child soldiers who experienced Profound Catastrophic Trauma in Ganta, Liberia, West Africa.

Methods: Participants (N = 130) were conscripted into combat at 6-13 years old. The model´s ability to reduce the symptoms of PTSD was evaluated with 20 participants using pre/post Clinician Administered PTSD Scale (CAPS). The model applies ten trauma modules based on accepted trauma recovery theory (Overwhelming Events, Encapsulation, Somatization, Recognition, Release, Resilience, Integration, New-Self, Rebuilding, and Commencement). Participants were trained to select one trusted "Companion." Each member of the pair learned to become a skilled trauma counselor for the other. These one-on-one relationships were solidified during training and continued afterwards.

Results: Mean pre/post scores showed a significant ($p < .001$) reduction of trauma symptoms by 33%. A sample of 10 videotaped CAPS (re-scored by a blinded independent rater) showed excellent inter-rater reliability with the original tests ($p < .001$). One year follow up CAPS assessments (N = 10) suggest additional reduction of PTSD symptoms continue to occur without further professional intervention.

Conclusions: Findings show the model may help reduce the effects of profound trauma in former child soldiers.

Participant Alert: There will be verbal examples of violent activities that child soldiers participated in and experienced and may be graphic in nature.

Best Laid Plans: Challenges and Benefits of Conducting Research With Refugees and Displaced Persons

(Abstract #196002)

Workshop/Case Presentation (Civil Ref, Res Meth) **Crystal Room, 3rd Floor**

Osterman, Janet, MD[1]; de Jong, Joop, MD, PhD[2]
[1]Boston University, Boston, Massachusetts, USA
[2]Vrije Universiteit, Amsterdam, Netherlands

This interactive workshop will discuss the challenges and benefits of conducting research with refugees and displaced persons. The presenters will illustrate some problems encountered in a research project working with a small yet mobile population of refugees from East Africa that will include issues of politics, staffing, recruitment, linguistics and access to translators. The presenters will review adaptations required to re-structure aspects of the project to complete the proposed aims. Further exploration of both challenges and benefits of conducting research in low-income settings with refugee and displaced persons will be presented based on substantial experience in post-conflict areas across Africa, Asia, and the Middle East. Participants will be encouraged to discuss their current and prior experience in conducting research with the refugee and displaced population and in both low-income and high-income countries. Participants may present current dilemmas and seek solutions to solve the difficulties, drawing on both the presenters and participants ideas and experiences. Topics may inlcude subject recruitment, need for translators or bilingual staff, culture and ecological validity, methodology to develop culturally valid instruments, and political violence, human rights violations and ethical implications that may cause modification of the research proposal.

Concurrent Session 13
Saturday, November 15
2:00 p.m. – 3:15 p.m.

Soldiers at War:
The Perspectives of Two Journalists

Addressing PTSD in Combat Troops Returning From Iraq and Afghanistan

(Abstract #198509)

Invited (Mil Emer, Media Ed) **Adams Ballroom, 6th Floor**

Kennedy, Kelly[1]
[1]Times News Service, Alexandria, Virginia, USA

An embedded reporter's personal experiences covering the wars in Iraq and Afghanistan will be presented. Specifically, the implications of sanitizing media coverage of war will be discussed. It will be argued that unless the details of the experiences are reported, a disservice is being done not only to service members, but also to their families, communities and health-care workers. Society has an excuse to believe PTSD is nothing more than a loss of courage or people trying to get over on the system by seeking benefits. With the details, it is hard to wonder how anyone could come out of such a situation unscathed.

Participant Alert: This presentation will include video, photos and descriptions of war that may be distressing to some participants.

How Iraq Veterans are Fighting the Next War Here in America

(Abstract #198511)

Invited (Sos Ethic, Mil Emer) **Adams Ballroom, 6th Floor**

McKelvey, Tara[1]
[1]The American Prospect, Washington, District of Columbia, USA

A look at the deeply scarred generation of US service members returning from the war in Iraq and the degree to which the government is neglecting their care here at home.

Treating Acute Stress Disorder

(Abstract #197561)

Master (Prev EI, Clin Res) **Monroe Ballroom, 6th Floor**

Bryant, Richard, PhD[1]
[1]University of New South Wales, Sydney, New South Wales, Australia

Acute stress disorder (ASD) describes initial stress reactions that are predictive of chronic posttraumatic stress disorder (PTSD). Since the September 11 terrorist attacks, there has been renewed international interest in early identification of acutely traumatized people and evidence-based intervention strategies. This masterclass will commence with an outline of the optimal ways to identify people shortly after trauma who are likely to develop long-term PTSD. The masterclass will provide a review of current assessment tools, as well as interactive discussion of strategies for assessing acutely traumatized individuals. A detailed outline of cognitive behaviour therapy strategies will be provided. Obstacles to treatment will also be discussed in the context of case studies.

Resiliency in the Face of Terrorism and Mass Casualty: Keys to our Understanding of Thriving, Surviving, and Making it to the Next Day

(Abstract #195858)

Symposium/Panel (Disaster, Prev El) **Grand Ballroom, 4th Floor**

Hobfoll, Stevan, PhD[1]; Bonanno, George, PhD[2]; Galea, Sandro, MD, PHD[3]; Shalev, Arieh, MD[4]

[1]Psychology, Kent State University & Summa Health System, Kent, Ohio, USA
[2]Columbia University, New York, New York, USA
[3]Epidemiology, University of Michigan, Ann Arbor, Michigan, USA
[4]Department of Psychiatry, Hebrew University School of Medicine and Haddasah Hospital, Jerusalem, Israel

The study of terrorism and mass casualty, has focused on pathological responses. However, many develop few symptoms or initially show upset, but recover quickly.

We address the pathways of resilience and resistance to mass casualty and terrorism around the world and how to better define resilience, resistance, and recovery. We explore the epidemiology and conceptualization of resilience, and future research. This broadens our theoretical understanding of people´s responding to trauma, key to public health intervention, and carries enormous potential for building a Psychology of Human Strength in the face of adversity.

We present work on the consequences of terrorism, mass conflict, mass epidemic, and war from the World Trade Center attacks, the Madrid Bombings, Ethiopia, Israel and Palestine. This more complex understanding of resilience and resistance suggests important roles for individual differences in vulnerability and resiliency-related characteristics, situational differences in levels of exposure, the chronicity of exposure, and environmental contingencies. It highlights the relativity of resilience in light of the severity and chronicity of events. Given a lifetime of multiple severe traumas, continued functioning in life roles, and facing a new day, may be a sign of resilience and the access point for intervention to support future recovery.

Participant Alert: Graphic descriptions and photos may be shown.

Examining Posttraumatic Growth in Children and Youth: Cross-Cultural Findings

(Abstract #196281)

Symposium/Panel (Child, Cul Div) **Salon 1, 3rd Floor**

Kilmer, Ryan P., PhD[1]; Gil-Rivas, Virginia, PhD[1]; Alisic, Eva, MA, MSC[2]; Hafstad, Gertrud Sofie, PhD Candidate[3]; Taku, Kanako, PhD[1]; van der Schoot, Tom A. W., PhD[4]; Kleber, Rolf J., PhD[5]; Roof, Katherine A., BA[1]

[1]Psychology, University of North Carolina at Charlotte, Charlotte, North Carolina, USA
[2]Psychotrauma Center for Children and Youth, University Medical Center Utrecht, Utrecht, Netherlands
[3]Norwegian Centre for Violence and Traumatic Stress Studies, Oslo, Norway
[4]Psychotrauma Center for Children and Youth, University Medical Center Utrecht, Utrecht, Netherlands
[5]Department of Clinical and Health Psychology, Utrecht University, Utrecht, Netherlands

Although posttraumatic growth, positive change as a result of the struggle with trauma, has garnered considerable attention in the adult literature, the area is less well-developed for children and adolescents. Panelists will present findings using a new, revised measure of the construct in studies with youth in 4 different countries.

Posttraumatic Growth Among Children Impacted by Hurricane Katrina
Although PTG research is a burgeoning area, emphasizing the transformative elements of responding to adversity, relatively few studies have examined the construct among children. These presenters will describe briefly the development of the Posttraumatic Growth Inventory for Children – Revised and describe findings growing out of their NIMH-funded work examining children (aged 7-10 years) and caregivers affected directly by Hurricane Katrina and its aftermath. Interviews were conducted with 68 caregiver-child dyads one year post-Katrina (on average) and 52 of those same dyads 6 months later. Using both respondents´ reports, this presentation will include basic descriptive findings using the new measure and emphasize correlates of posttraumatic growth (PTG) in the child sample. It will focus specifically on the role of child characteristics, including self-system variables (e.g., perceived competence, future expectations) and cognitive resources and processes (e.g., realistic control expectations, rumination), as well as selected caregiver variables (e.g., caregiver self-rated PTG, caregiver-child relationship qualities, caregiver-guided positive re-framing). Developmental implications and future directions will be discussed.

Posttraumatic Growth in a Dutch Sample of Primary School Children
There is a small but growing body of literature suggesting that children surviving a traumatic event can experience posttraumatic growth (PTG), such as changing priorities, as well as adults. In general this knowledge is based on samples surviving a single type of traumatic event (e.g., road traffic accidents, a hurricane). In order to extend this knowledge to children who survived a wide range of events, we examined the existence of PTG and its relationship with posttraumatic stress and quality of life in a random sample of 1770 Dutch primary school children (age range 7.4-13.7, mean age 10.24; 50% boys). A significant minority of the children reported substantial growth after their worst experience ever. Traumatized children (according to criterion A1 for PTSD in *DSM-IV*) reported more growth than children who reported a worst experience that was not considered traumatic. There was a strong relationship between PTG and posttraumatic stress, with children experiencing more posttraumatic symptoms also reporting more growth. The results and their theoretical and clinical implications will be discussed during the presentation.

Family Correlates of Posttraumatic Growth in Children and Adolescents
Despite interest in the caregiving system in other fields of trauma research, the family has received little empirical attention in the posttraumatic growth literature. The quality of the caregiving system has been well-documented as a protective factor in child risk and resiliency research. Family functioning and caregiver characteristics may therefore be central in understanding the process underlying posttraumatic growth in children. The present study investigates how child posttraumatic growth relates to family cohesion and expressiveness, caregiver resources, caregiver mental health and caregiver posttraumatic growth. One hundred and seven Norwegian children (aged 6-18) and their parents exposed to the 2004 Southeast Asian Tsunami, were interviewed 10 months and 2 1/2 years post disaster. Posttraumatic growth was measured in children and their parents utilizing the Posttraumatic Growth Inventory (PTGI) and PTGI for Children-Revised version, accordingly. The results contribute to illuminate the process of posttraumatic growth in children, and places focus on the role of the child's immediate environment in posttraumatic adjustment.

Posttraumatic Growth Among Japanese Middle School Students
Posttraumatic growth (PTG), positive psychological changes experienced as the result of the struggle with major life crises, has been examined among adults in several countries, using the translated versions of the PTG inventory (PTGI). On the contrary, there have been few studies that have examined how children outside the U.S. may experience PTG. Studying PTG in children raises questions about their social and cognitive development in the given cultural context. to examine the potential cultural differences in PTG among children, the Japanese version of the PTGI for Children (PTGI-C-J), an adaptation of the original English version developed by Kilmer, Gil-Rivas, and colleagues, was

examined in a sample of 314 middle school students, with a mean age of 13.52 years (SD = 0.97). Results showed that Japanese youth did report PTG following their traumatic/stressful life events and that youths who experienced traumatic events within the past year reported more growth than youths who did not experience any traumatic events, supporting the construct validity of the PTGI-C-J. Relationships between cognitive processing, including intrusive and deliberate rumination about the event, and PTG, as well as implications for future research on cultural elements of PTG among children will be discussed.

Psychosocial Effects of Terrorist Threat and Close Protection in Politicians

(Abstract #195945)

Symposium/Panel (Prev El, Sos Ethic) **Crystal Room, 3rd Floor**

Gersons, Berthold, Professor[1]; Nijdam, Mirjam, MSC[2]; Friedman, Merle, PhD[3]; McFarlane, Alexander, MB, BS, MD, FRANZCP[4]
[1]Psychiatry, AMC UNiversity of Amsterdam / Centrum '45, Amsterdam, Noord-Holland, Netherlands
[2]Center for Pyshological Trauma, AMC University of Amsterdam, Amsterdam, Noord-Holland, Netherlands
[3]South African Institute for Traumatic Stress, Saxonwold, Johannesburg, South Africa
[4]The Centre of Military and Veterans' Health, Adelaide, South Australia, Australia

Introduction: Following two political murders in the Netherlands, politicians under terrorist threat have received increasingly stringent security measures. What was once perceived as a safe and tolerant country where ministers ride their bike to work, suddenly it turned into a culture in which terrorist groups threatened to kill politicians and aimed at evoking anxiety in the whole society. Both the life threat in itself and the protective measures that are taken can influence the lives of the politicians being protected, especially if the threat level requires that close protection is introduced. Therefore, it may be useful to offer them some form of psychosocial advice or support. This panel will address the current practice of advising politicians and their families, how to cope with protectors, how to stimulate resilience, and propose a model to understand the dynamics of traumatic stress in this situation.

Preventing Traumatic Distress for Politicians Under Terrorist Threat and Close Protection
The National Coordinator for Counterterrorism (NCTb) in the Netherlands is responsible for the national system of surveillance and protection. The department coordinates the surveillance and protection of objects, services and persons whose safety and undisturbed functioning are matters of national importance. Close protection can put great pressure on the person concerned and on his or her immediate environment. The protective measures are taken because there is an actual threat and risk. The basic principle is a protected person should be able to lead a life that is as normal as possible, within the restrictions of the protective measures. However, the confrontation with information that groups have actual plans to kill a politician evokes signs of traumatic distress like hyperalertness, sleep problems, irritation, but also disbelief, regressive reactions or hardening of political standpoints. There is no place for privacy anymore and everything needs to be planned because the protectors need to know. The NCTb has asked for help to apply the knowledge from the traumatic stress field in these complex and sensitive situations. The purpose of this presentation is to discuss the current practice of advising politicians and their families, aiming at prevention of traumatic distress. Also attention will be paid to the difficult context in which the government has to work.

Terrorist Threat and Close Protection: A Model for Coping Responses in Politicians
Knowledge from the literature on psychosocial reactions to stress and traumatic stress can help the people involved to gain insight into their own reactions, which may be very diverse. The coping model we constructed shows how the impact of threats and protection depends on the way in which a protected person perceives and consequently copes with the stress. A literature review on this topic revealed several relevant theoretical perspectives, which were confirmed by interviews with Dutch politicians and their protectors. Several recommendations were made to the government based on this study; emphasizing different ways in which psychological insights can help politicians cope with the threat and protection in the best possible way.

Optimizing Resilience and Personal Growth in Close Protection
As is evident from the limited research that has been conducted in this area, there are different responses to the advent, continuation and cessation of close protection. In considering optimal ways of enabling highly functioning politicians to negotiate this complex challenge, differing responses to the anticipation of possible trauma as well as ongoing stress and traumatic stress must define interventions. Resilience may offer individuals protection from aspects of both stress and traumatic stress, and there is much about resilience that can be acquired. Methodologies for increasing the chance of successfully transferring skills related to increasing resilience and successful cooperation with protectors will be considered. In addition aspects of resilience that may increase the operating efficiency of the protectors will also be addressed.

Advising Politicians Regarding Their Professional Practice and Social Environment
Individuals in public positions, such as politicians or senior political commentators, by their nature tend to be direct and open members of the community, who readily confront issues with debate and action. In a democratic society there is little expectation of such discourse would be met with personal threats or realistic danger. The ideal of an open democracy is that disputes resolve through the debate which is the corner stone of such political systems. When a politician becomes the focus of personal threat, the individual faces a major psychological dilemma. Such threat involves a great deal of unpredictability, both in terms of the probability of the threat being carried out and also the extent to which it places family and colleagues at risk. Notwithstanding the psychology of threat, it is a critical issue in assisting an individual to accommodate to the circumstances of perceived and anticipated threat. There has to be a balanced response between denying the threat and becoming excessively avoidant and to withdraw from political discourse. Furthermore, the veil of danger can subtly modify and change an individual´s political ideals and characteristic responses to challenge. Teaching methods of practical self-physical protection can assist overcoming feelings of helplessness. Partners and children also should be helped to use active strategies to minimise risk.

Revictimization: Examining Cognitive, Emotion, and Social Risk Factors

(Abstract #196319)

Symposium/Panel (Clin Res, Practice) **State Ballroom, 4th Floor**

DePrince, Anne, PhD[1]; Combs, Melody, MA[2]; Shanahan, Michelle, MA[3]; Gobin, Robyn, MS[4]; Freyd, Jennifer, PhD[5]; Chu, Ann, MA[1]; Dietrich, Anne, PhD[6]
[1]University of Denver, Denver, Colorado, USA
[2]Psychology, University of Denver, Denver, Colorado, USA
[3]Psychology, University of Denver, Denver, Colorado, USA
[4]Psychology, University of Oregon, Eugene, Oregon, USA
[5]University of Oregon, Eugene, Oregon, USA
[6]Private Practice, Vancouver, British Columbia, Canada

Revictimization is linked to worse health outcomes than single/no victimization; thus, identifying risk factors is critical to public health. Panelists will describe diverse methods used to identify mechanisms (e.g., emotion regulation, cognitive/social processing, appraisals) that may translate risk as well as discuss prevention implications.

Revictimization in Young Women: A Test of the Interpersonal Schema Hypothesis
Revictimization poses a serious and preventable public health problem. Drawing on interpersonal schema theory, Cloitre (e.g., 1998) proposed revictimization risk may be translated via schemas that relationships involve harm. to date, cognitive methods have not been applied to test the automatic associations characteristic of schemas. The lexical decision-making priming task evaluates the speed-up in reaction time to a word presented after another word from the same schema (e.g., cat-dog) relative to other conditions. We predicted that relationship words (e.g., lover, partner) would prime victimization words (e.g., assault, rape) in revictimized women, but not in singly- or non-victimized women. In a sample of college-aged women (N=130), those who reported victimizations by a close other before and after age 18 showed more priming in relationship-victimization trials than singly- or non-victimized women. Priming was unrelated to dissociation and PTSD symptoms. Implications for treatment, including interventions that target beliefs and expectations about relationships, will be discussed.

Trust and Revictimization Among Betrayal Trauma Survivors
The link between the experience of childhood sexual abuse and subsequent revictimization in adulthood has been widely reported in the literature. The theories that have been proposed to explain this link have heretofore failed to examine inaccuracy in evaluations of trust and awareness for betrayals in interpersonal contexts as factors contributing to the perpetuation of revictimization. The present study examined revictimization within a betrayal trauma framework. Betrayal trauma theory posits that the experience of life threatening traumas perpetrated by someone close to the victim might damage cognitive mechanisms that normally allow individuals to make accurate evaluations of trust. A sample of 272 college students completed questionnaires regarding betrayal trauma history, willingness to trust, and accuracy for detecting betrayal. Preliminary data reveal higher rates of betrayal, lower awareness levels, and greater likelihoods of continuing a relationship following an interpersonal betrayal among high betrayal trauma survivors. These results suggest revictimization risk may be linked to accurate identification of betrayals and the ability to initiate proper self-protective actions.

Physiological Activation and Trauma Appraisals: Potential Mechanisms of Risk Detection and Revictimization
Child abuse increases the risk of later victimization for women. Revictimization is associated with more severe physical, psychological, and social problems than single or no victimizations. Given this serious public health issue, research has increasingly focused on identifying mechanisms that might translate risk, such as risk detection (i.e., the ability to detect danger cues in social situations). While risk detection deficits have been linked to revictimization, little is known about physiological and appraisal processes that contribute to such deficits. to address these issues, an ethnically-diverse community sample of 82 women (Age: Mean=30.47, SD=6.15) listened to an audiotape of a risky dating situation. All women reported at least one experience of interpersonal violence; the average number of events perpetrated by different people was 4.74. Based on previous research using this task, we examined parasympathetic (e.g., vagal tone) and sympathetic (e.g., pre-ejection period) activation as well as self-reported physiological arousal. Participants also reported on trauma-related appraisals and post-trauma symptoms. We discuss the relative contributions of physiological activation and trauma-related appraisals (e.g., fear, shame) to risk detection and symptoms (e.g., PTSD). Implications for models of and prevention programs for revictimization will be considered.

PTSD and Associated Features in Revictimization of Men and Women
It is well accepted that childhood maltreatment often results in longterm negative outcomes, including PTSD and associated features to PTSD. Adults with childhood maltreatment histories are also at increased risk of psychological, physical and sexual revictimization. In this presentation, results from a study on revictimization of 207 adults with childhood maltreatment histories will be discussed. The postulated risk factors of PTSD, affect dysregulation and interpersonal relatedness problems are examined via logistic regression analyses for men and women, separately. Controlling for effects of childhood maltreatment, predictors of physical victimization, sexual victimization and abuse by a partner vary for women and men. Potential mechanisms by which these predictors increase risk of revictimization will be summarized.

From Evidence to Practice: Knowledge Synthesis, Dissemination and Transfer for Better PTSD Treatment

(Abstract #196367)

Symposium/Panel (Clin Res, Media Ed) **Wabash Room, 3rd Floor**

Creamer, Mark, PhD[1]; Lewis, Virginia, PhD[1]; O'Donnell, Meaghan, PhD[1]; Forbes, David, PhD[1]; Couineau, Anne-Laure, MA[1]
[1]University of Melbourne, Melbourne, Victoria, Australia

New knowledge about mental health does not automatically lead to better outcomes. The term "knowledge translation" has gained prominence as decision makers focus on how to use research findings to improve services for better consumer outcomes. This symposium presents an example of the knowledge cycle in relation to PTSD treatment.

Knowledge Synthesis
Purpose: This paper provides the framework for the symposium, including reviewing current approaches to "knowledge transfer", before describing the rigorous process by which the Australian Guidelines for the Treatment of Adults with PTSD and ASD were developed as an example of knowledge synthesis.

Main Points: The task of synthesising knowledge for the purpose of producing treatment guidelines requires a clear and rigorous approach. Clearly defined criteria have been established for reviewing evidence, including clear assessment of designated population, randomisation, fidelity assessments of interventions, and blind assessment among others. Guidelines are then developed on the basis of studies that have met these criteria. While there may be issues around the exclusion of some evidence that does not meet the highest criteria, and around some of the characteristics that are shared by studies that do meet the highest criteria, the necessity for valid synthesis of knowledge requires such strict criteria. At the same time, active involvement of key stakeholders is crucial if guidelines are to be acceptable to the target population.

Conclusion: Knowledge synthesis is a complex task that requires a high level of consultation and negotiation with key stakeholders.

Knowledge Dissemination to Diverse Audiences
Purpose: Promoting best practice can be challenging, with practice guidelines and new evidence-based interventions infrequently adopted by mental health practitioners.

Main Points: Research points to the fact that people´s receptiveness to innovation and change is varied and that communication strategies and tools that promote change need to be tailored to organisations and their staff. Dissemination of information about best practice for mental health treatment needs to target different audiences. The dissemination strategy associated with the Australian PTSD Guidelines will be described. Disseminating knowledge to an audience that includes researchers, policy makers, service developers, clinicians and consumers requires different products and strategies. This paper includes a critical review of strengths and weaknesses of the approach, as well as recommendations for the best way to disseminate information about mental health practice.

Conclusion: Significant effort and resources are required for successful knowledge dissemination, but this step in the knowledge transfer cycle cannot be overlooked if practice change is required on a state or national scale.

Knowledge Transfer for Best Practice and Better Outcomes
Purpose: This paper reviews theories of individual and organisational behaviour change as they apply to knowledge transfer for mental health practitioners and their organisations.

Main Points: Research demonstrates that uptake of recommended practices is facilitated by enlisting the support of organisational leadership, involving stakeholders from the start in policy or treatment protocol development, training key staff in new practices, providing follow-up systems, and putting in place feedback and evaluation systems. With financial support from the Australian government, research is underway to enhance effective implementation of evidence based practice in two key trauma population service areas: veterans and survivors of sexual assault. The models adopted in this project will actively involve clinical staff and management from the start to encourage the change to consistent use of recommended practices. It will also include information provision to clients attending the pilot sites, training of selected staff and the establishment of follow-up tools and processes to embed practices learned. The research will evaluate the extent to which knowledge transfer has been successful in these two clinical settings.

Conclusion: Knowledge transfer is a complex, multi-faceted task that requires an active commitment from health care organisations and providers.

Papers
PTSD in Displaced Populations

Salon 2, 3rd Floor

Chair: Eranda Jayawickreme, MA,
Psychology, University of Pennsylvania, Philadelphia, Pennsylvania, USA

Distress, Well-Being and War: Qualitative Analysis of Civilian Interviews From North-East Sri Lanka

(Abstract #196136)

Paper Presentation (Civil Ref, Asses Dx)

Jayawickreme, Nuwan, MA[1]; Jayawickreme, Eranda, MA[1]; Foa, Edna, PhD[2]; Seligman, Martin, PhD[2]; Goonasekera, Michelle A., MBBS[3]
[1]Psychology, University of Pennsylvania, Philadelphia, Pennsylvania, USA
[2]University of Pennsylvania, Philadelphia, Pennsylvania, USA
[3]University of Peradeniya, Peradeniya, Sri Lanka

The study of local idioms of psychological distress and wellness in specific communities is an important endeavour, as such expressions stem from a specific value or belief orientation (Lopez & Guarnaccia, 2000, Lu & Gilmour, 2004). Understanding the acceptable means of communicating distress and wellness in a community is essential if one is to develop a culturally competent model of mental health (Osterman & de Jong, 2007). Such a study must use ethnographic, epidemiological and clinical research methods if one is to understand how the social world interacts with the individual´s psychological processes. Ethnographic research allows for an in-depth examination of a specific culture´s conceptualization of distress and wellness. The current project involves the analysis of an ethnographic data set that offers insight into how war-affected Sri Lankans conceptualize and express distress and well-being. Ethnographic data collected from 1450 individuals in war-affected areas of North-Eastern Sri Lanka were analyzed using open and axial coding methods. The data consisted of the Adult War Problems and Adult Competencies Interviews. Results indicated seven clusters: emotional problems, social problems, impact of problems, presence of support networks, relationship with family and community, religious and social involvement, and personal growth.

PTSD, Depression and Psychosis in Somali Refugees

(Abstract #195907)

Paper Presentation (Civil Ref, Asses Dx)

Kroll, Jerome, MD[1]; Yusuf, Ahmed, BA[2]
[1]Community-University Health Care Clinic, University of Minnesota, Minneapolis, Minnesota, USA
[2]Community-University Health Care Clinic, Minneapolis, Minnesota, USA

This paper reports on the major patterns of psychiatric disorders in Somali refugees (N=476) attending an inner city clinic from 2000-2007. The majority of patients were caught up in the violence and social disruption that accompanied the Somali Civil War of 1991. Diagnoses were made by *DSM-IV* criteria. Main outcome measures (diagnoses, age cohort, sex) were analyzed by Chi-square tests. Forty-nine percent of male patients (N=214) were under age 30 years and presented primarily (87 0f 104) with acute psychotic illnesses of mixed schizophrenic and affective components ($p<.001$). Older men show predominantly depressive and PTSD symptomatology. Seventy-seven percent of women patients (N=262) were over age 30 and presented primarily with depressive/PTSD disorders ($p<.001$). Patterns of illness and adjustment vary widely by age and gender cohorts, reflecting the relevance of these variables on different trauma and loss experiences and cultural and religious shaping of adjustment and symptom formation. War trauma experienced in childhood, early malnutrition from famines, and excess Khat use in male adolescents provide partial explanations for the high rate of psychoses.

The Psychological Impact of the Kidnapping in Colombia: An Approach From the Media

(Abstract #195829)

Paper Presentation (Media Ed, Civil Ref)

Manrique Cortés, Jenny, Journalist, MA in International Affairs[1]
[1]Dart Center for Journalism & Trauma, Ochberg Fellow 2006, Capital Federal, Buenos Aires, Argentina

The kidnapping is one of many traumatic events to which a human being can be exposed: murders, thefts, catastrophes, violations, etc. Unlike these facts, which have an end, the kidnapping exposes victims to a chronic trauma. It makes them to question about the most fundamental beliefs on the confidence, the life, the death, the kindness and the evilness. It is inevitably connected With the psychology of submission: that is what the kidnappers do, to exercise a despotic control over all the aspects of victims´ lives. For more than four decades, Colombia has been plagued by one of the longest armed conflicts in the Western Hemisphere: a civil war that has led to catastrophic rates of violence and human right violations across the country. One of the biggest crimes that armed actors have comitted to maintain the war alive is the kidnapping. Hostages are an exchangeable merchandise for money or political intentions. During the last ten years 23.401 personas had been kidnapped in the country and nowadays 3.134 hostages remain in the jungle, Without freedom. The coverage of this issue that have left tragic wounds in the whole society, is a big challenge for journalists. The topic implies on the one hand the trauma of relatives who expect their beloved ones return alive, and on the other hand the trauma of the victims demonstrated in the heart-breaking proofs of live that media had shown, and the testimonies of liberated hostages or the ones who have scaped. In adittion, there is a trauma in the society, which shakes or strikes With these stories, feeling sad or even unsafe about the crime. This presentation will focus on the role of journalism covering this important issues.

Papers
Predictors and Correlates in PTSD

Salons 7 – 9, 3rd Floor

Chair: Erika Wolf, MA,
National Center for PTSD, Boston University; VA Boston Healthcare System, Boston, Massachusetts, USA

Stress Hormones and Peritraumatic Dissociation as Causal Pathways Between Trauma History and PTSD

(Abstract #196425)

Paper Presentation (Bio Med, Asses Dx)

Irish, Leah, MA[1]; Karazsia, Brian, MA[2]; Sledjeski, Eve, PhD[3]; Fallon, William, MD[4]; Spoonster, Eileen, RN[4]; Delahanty, Doug, PhD[1]
[1]Kent State University, Kent, Ohio, USA
[2]Psychology, Kent State University, Kent, Ohio, USA
[3]Wesleyan University, Middletown, Connecticut, USA
[4]Summa Health System, Akron, Ohio, USA

Prior trauma exposure predicts the development of PTSD symptoms (PTSS) following a subsequent trauma. The aim of the present study was to evaluate peritraumatic dissociation and initial hormone (cortisol and epinephrine) responses to trauma as mediators of the relationship between prior trauma characteristics and PTSS in 265 motor vehicle accident (MVA) victims. Two structural equation models were tested: one with cortisol and peritraumatic dissociation as mediators and one with epinephrine and peritraumatic dissociation as mediators. Results revealed poor model fit and modifications were made to the models. Changing cortisol and epinephrine from mediators to indicators of the PTSD construct dramatically improved model fit (final cortisol model: (29)=21.74, p>.05, CFI=1.0, RMSEA=.00; Final epinephrine model: (29)=42.77, p>.05, CFI=.99, RMSEA=.04). These results suggest that while peritraumatic dissociation significantly mediates the relationship between trauma history and PTSS, cortisol and epinephrine may serve as markers of PTSS rather than causal pathways. Results also suggest that different event and response characteristics of the prior traumas may affect PTSD through different causal pathways.

PTSD and Weight Gain: Results From the National Comorbidity Study – Replication (NCS-R)

(Abstract #196494)

Paper Presentation (Bio Med, Sos Ethic)

De Vries, Giel-Jan, MSC, MA[1]; Olff, Miranda, PhD[2]
[1]Center for Psychological Trauma, Academic Medical Center, Amsterdam, Netherlands
[2]Psychiatry - Center for Psychological Trauma, Academic Medical Center, Amsterdam, Netherlands

Objective: Several studies found that PTSD is associated to obesity and physical health. Obesity has been observed in specific groups such as male veterans and police officers, but not in the general population. The way PTSD and obesity are related remains unclear.

Method: The NCS-R is a nationally representative face-to-face household survey of 5692 respondents aged 18 years or older conducted between February 2001 and December 2002. All respondents were administered a diagnostic interview determining psychopathology, social and background information and self-reported height and weight. Obesity has been defined as having a Body Mass Index (BMI)>35.

Results: Higher BMI is associated with 12-month and current PTSD even when adjusting for sociodemographic background variables as age, sex, education and family income. Obesity is associated with lifetime, 12-month and current PTSD with patients having more risk at obesity than those without PTSD even when controlling for coexisting psychopathology. Moreover, BMI was found positively associated with the number of PTSD symptoms. Additional analyses are performed to rule out alternative explanations as medication use, eating behavior and sleeping problems.

Conclusions: PTSD is associated with weight gain and obesity in the general adult population as well.

The Relationship Between Personality and Personality Disorder in a PTSD Sample

(Abstract #196455)

Paper Presentation (Clin Res, Asses Dx)

Wolf, Erika, MA[1]; Klunk-Gillis, Julie, PhD[2]; Paysnick, Amy, BA[2]; Vanderhoef, Kimberly, BA[2]; Fabricant, Laura, BA[2]; Miller, Mark, PhD[2]
[1]National Center for PTSD, Boston University; VA Boston Healthcare System, Boston, Massachusetts, USA
[2]National Center for PTSD, Behavioral Sciences Division, VA Boston Healthcare System, Boston, Massachusetts, USA

This study examined the relative contributions of the higher-order normal-range personality traits negative emotionality (NEM), positive emotionality (PEM), and constraint (CON) in predicting personality disorder (PD) severity in a PTSD sample. One hundred fifty participants (83% male, 83% veterans) completed self-report measures of personality (Tellegen´s MPQ), PDs (LA Clark´s SNAP), and PTSD (PCL). Rates of PTSD-PD comorbidity were high and ranged from 3.3% for narcissistic PD to 40% for borderline PD. A series of multiple regressions demonstrated that, relative to other personality traits, (a) high NEM contributed most strongly to borderline, paranoid, dependent, and schizotypal PD (beta range: .37 - .71), (b) low CON contributed most strongly to antisocial PD (beta = -.46), (c) low PEM was the best predictor of schizoid PD (beta = -.67) while high PEM was the best predictor of histrionic (beta = .58) and narcissistic (beta = .42) PD, 3) low PEM and high NEM contributed relatively equally to avoidant PD (betas = -.45 and .48, respectively), and (d) high NEM and high CON contributed equally to obsessive-compulsive PD (both betas = .29). These differential patterns suggest heterogeneity in the core personality traits that underlie the PDs, which has implications for case conceptualization and treatment.

Complex Trauma, Complex Needs: Building Capacity to Address Trauma and DV in Public Systems

(Abstract #196439)

Workshop/Case Presentation (Commun, Sos Ethic) **Salons 4-6, 3rd Floor**

Warshaw, Carole, MD[1]; Pease, Terri, PhD[1]; Blumenfeld, Susan, MSW[1]
[1]National Center on Domestic Violence, Trauma & Mental Health, Chicago, Illinois, USA

Advances in the fields of traumatic stress, child development and neuroscience are generating new models for understanding the impact of early experience on health and well-being and for delineating the complex interrelationships between domestic violence (DV), trauma and mental health. These models, particularly when grounded in survivor and advocacy perspectives, provide a more useful framework for addressing complex trauma in the context of ongoing DV and for supporting attachment and parenting capacities. This workshop will provide an overview of research and community-based perspectives on responding to DV in the context of other lifetime trauma for both adult survivors and their children and emerging models for treating complex trauma in the context of ongoing DV, where legal, safety and custody issues abound. It will also offer practical strategies for building system capacity to address these issues in clinical and advocacy settings.

Analysis of presenters´ experiences working with local agencies and city and state systems in assessing needs, developing collaborative practice models, piloting training curricula and providing on-site consultation and TA will be shared and evaluation discussed. Critical policy and systems integration issues will also be discussed along with recommendations for improving service delivery systems for adult survivors and their children.

Implementing Trauma-Informed Care in Residential Mental Health Settings for Youth

(Abstract #196462)

Workshop/Case Presentation (Clin Res, Child) **Salon 3, 3rd Floor**

Hummer, Victoria, MSW[1]; Dollard, Norin, PhD[1]; Vergon, Keren, PhD[1]
[1]University of South Florida, Tampa, Florida, USA

Given the high rates of complex trauma exposure in the histories of youth in residential and group care, it is essential that youth receive evidence-based assessment and mental health treatment for trauma within these settings. Trauma-informed care is a comprehensive approach that includes prevention, supports trauma-specific intervention, and infuses knowledge and behaviors into all aspects of organizational operation. Strategies include identification of agency resources and assets to support the needed organizational cultural shifts to successfully implement trauma-informed care. The proposed workshop presentation informs stakeholders and consumers of residential mental health settings of a method for conducting an organizational self-analysis for the implementation of trauma-informed services at the organizational level. Drawing from the literature and the results of a Florida study, presenters will discuss the effects of complex trauma on children, adolescents and their families, principles of trauma-informed care, and current strategies for necessary change within organizational culture. Barriers and supportive factors within participant organizations will be addressed within facilitated small group discussions. Participants will then identify preliminary steps, timelines, and resources needed to begin to implement trauma-informed care within their agency or system.

Concurrent Session 14
Saturday, November 15
3:30 p.m. – 4:45 p.m.

Low Income and Ethnic Minority Women: Multiple Trauma and Effects, Culturally Sensitive Treatments

(Abstract #195898)

Symposium/Panel (Cul Div, Clin Res) **Salon 2, 3rd Floor**

Triffleman, Elisa, MD[1]; Kaltman, Stacey, PhD[2]; Campbell, Rebecca, PhD[3]; Greeson, Megan, BA[3]; Bybee, Deborah, PhD[3]; Raja, Sheela, PhD[4]; Krupnick, Janice, PhD[2]; *Green, Bonnie, PhD[2]*
[1]Private Practice, Port Washington, New York, USA
[2]Georgetown University, Washington, District of Columbia, USA
[3]Michigan State University, East Lansing, Michigan, USA
[4]Psychology, University of Illinois at Chicago, Chicago, Illinois, USA

There is an information shortfall about trauma in ethnic minorities. Culturally sensitive treatments have not been empirically tested. This symposium, organized by the ISTSS Diversity Committee, will examine data from Latina and largely African American low-income samples. Interventions adapted or developed for these groups will be presented.

The Relationship Between Trauma and Depression
Recent epidemiological data suggests that foreign-born Latino immigrants have a lifetime and past-year prevalence of psychiatric disorders of 24% and 13% (Alegria et al., 2007). Trauma exposure is often overlooked as a risk factor for psychiatric morbidity. This is especially important among immigrants from Central American countries with long histories of political violence and war. The purpose of this study was to examine the role of trauma, immigration-related, and demographic variables in predicting depression among Latina immigrants from a larger treatment trial. The case-control study included 136 depressed and 62 non-depressed women. On average, participants had been in the US for 8 years (sd = 5.06) and 56% were from Central America. The most commonly reported traumas included adult and childhood physical assault (36%, 27%), traumatic bereavement (28%), and rape (21%). In bivariate analyses, younger age, being non-married, fewer years since immigration, history of trauma exposure and number of trauma types were associated with depression. In a multivariate analysis, age, marital status, years in the US and trauma exposure contributed independently to the prediction of depression. This suggests that trauma exposure is an important risk factor for depression among Latina immigrants and has important implications for depression treatment programs.

The Health Impact of Lifetime Trauma and Violence in a Diverse Sample of Female Veterans
This study examined the co-occurrence of childhood sexual abuse, adult sexual assault, intimate partner violence, and sexual harassment in a predominantly African American sample of N=268 female veterans, randomly sampled from an urban Veterans Administration hospital women´s clinic. Overall, 59% had been sexually abused as children, 39% had been sexually assaulted at least once as an adult, 74% were victims of adult IPV, and 71% had been sexually harassed at least once. Hierarchical and iterative cluster analyses were used to identify four patterns of women´s lifetime experiences of violence co-occurrence. The first cluster (n=96) experienced relatively low levels of all four forms of violence; the second group (n=42), high levels of all four; the third (n=59), sexual revictimization across the lifespan with adult sexual harassment; and the fourth (n=70), high intimate partner violence with sexual harassment. This cluster solution was validated in a theoretically-driven model that examined the role of PTSD as a mediator of physical health symptomatology. In SEM analyses PTSD fully mediated the relationship between violence and physical health symptomatology (RMSEA=.03, IFI=.99, CFI=.99, indirect effects p<.05). Consistent with a bio-psycho-immunologic model, PTSD levels more strongly predicted pain-related physical health symptoms compared to non-pain health problems.

IPT for Low-Income Women with PTSD After Interpersonal Trauma
This presentation will describe a small randomized trial of Group Interpersonal Psychotherapy (IPT) for low-income, predominantly minority women who had PTSD subsequent to histories of interpersonal trauma, i.e., sexual or physical assault or abuse. Non-treatment seeking women were recruited at public sector primary care and family planning clinics. Forty-eight women were randomized to an IPT group or a wait-list control group. Results showed that women who participated in IPT groups (mean baseline CAPS= 65.1) had significantly more reduction in PTSD than those on the wait-list (mean baseline CAPS=62.6) with mean change on CAPS for the IPT group =-24.6 versus mean change for the control group = -3.06, and significantly more reductions in depression (mean change on Hamilton Depression Scale for the IPT group = -6.27 versus mean change for the control group = -0.73) at the end of treatment . Participants in the control group were more than twice as likely as those who participated in treatment groups to still meet criteria for the PTSD diagnosis at termination (71% versus 30%). There were also significant differences favoring the treatment group in interpersonal functioning scores, with the IPT group doing better on measures of interpersonal sensitivity and lack of sociability.

Discussion: Accessible, Innovative, Appropriate Interventions for Low Income Women
Trauma occurs at high rates in low-income and minority populations, and the need for treatment of related disorders is high. However, access to treatment is limited for these populations for a variety of reasons. The Georgetown Center for Trauma and the Community is developing approaches to increase access to novel treatments through primary care and social service settings. In this discussion, preliminary data from two studies underway at the center will be described, one comparing different methods of recruitment and retention, and one developing and testing a new modular repeating psycho-educational/interpersonal skills group, both targeting low-income African American women with PTSD and depression symptoms in safety-net primary care settings.

Policy Issues in Immediate and Intermediate Response to Disaster and Terror

(Abstract #196306)

Symposium/Panel (Sos Ethic, Disaster) **Crystal Room, 3rd Floor**

Seyle, D. Conor, PhD[1]; Watson, Patricia, PhD[2]; Lee, Linda, MSW, LCSW[3]; *Ligenza, Linda, LCSW*[4]; Ryan, Pamela, PhD[1]
[1]Psychology Beyond Borders, Austin, Texas, USA
[2]Dartmouth College, White River Junction, Vermont, USA
[3]Louisiana State University Health Sciences/Children's Health Fund, Baton Rouge, Louisiana, USA
[4]SAMHSA, North Bethesda, Maryland, USA

Three speakers present perspectives on how policy guiding post-terrorism and post-disaster response can be shaped to support the psychological health of survivors. A discussant from the Substance Abuse and Mental Health Services Administration (SAMHSA) examines fit with existing U.S. policy.

Policy and Psychological First Aid
The National Center for Posttraumatic Stress Disorder and the National Child Traumatic Stress Network were commissioned by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Mental Health Services (CMHS) to develop an evidence based field operations manual for immediate post disaster mental health response. A SAMHSA supported expert review panel was convened March 31-April 1, 2005 to gather contributions from those coordinating and participating in disaster response for the Psychological First Aid (PFA) manual. This manual has been accepted as an evidence informed document that assists in the provision of training and technical assistance required by states in the U.S. to deliver the Crisis Counseling Assistance and Training Program (CCP) funded by the Federal Emergency Management Agency (FEMA) in the cases of federally declared disasters. The policies that drive the CCP and how the PFA manual applies in relation to the needs of disaster survivors will be discussed.

Bridging the Policy Gap: Partnerships Between Universities and NGOs as a Method for Addressing Needs
The Louisiana State University Health Sciences Division (LSUHSC) has partnered with the Children's Health Fund (CHF) to address needs of Hurricane Katrina affected children and families in the Gulf Coast region of Louisiana and the Capital area of Baton Rouge. These services were designed to be delivered not only in the immediate post disaster phase, but continue through the intermediate and longer term recovery process as well. This is necessary due to the lack of policies that address the need for post disaster mental health services in the existing health and mental health service delivery systems on either the local or statewide levels outside of the provision of continuity of care for individuals already engaged with these public services (e.g. seriously and persistently mentally ill clients or physically disabled/special needs patients). The partnership of local University services and not-for-profit organizations can fill a gap to address the needs of those suffering with emotional distress in the aftermath of a mass catastrophe such as Hurricanes Katrina and Rita. Local, state and national mental health policies that facilitate these partnerships need to be designed in anticipation of continuing needs beyond the immediate response phase of a large scale or scope disaster.

How to Best Mitigate the Impact of Mass Trauma: Recommendations From an Assembly of Experts
In 2004 an international nonprofit organization convened an assembly of more than 90 experts working in the field of psychological trauma including terrorism-counterterrorism policy, political science, journalism and related fields with the goal of collectively identifying strategies for how individuals and societies can reduce the impact of terror attacks. These experts collectively developed a set of five recommendations for how individuals and societies can most effectively respond to these events: facilitation of informed dialogue about managing the psychological response to terrorism; building societal resilience through preparedness, treatment, and community support; facilitation of collaborations across people working in different domains related to terrorism; exploring and modeling conflict resolution methods; and encouraging and supporting moderates over extremists. This presentation discusses these recommendations through the perspective of how they can be best translated to specific policies local, national and international bodies can implement in responding to terror attacks and natural disasters.

Torture and Mental Health: What is Torture, and How Should Professional Organizations Respond?

(Abstract #195964)

Symposium/Panel (Sos Ethic, Civil Ref) **Adams Ballroom, 6th Floor**

Scott, Catherine, MD[1]; Berthold, Megan, MSW, PhD[2]; Briere, John, PhD[1]
[1]University of Southern California, Los Angeles, California, USA
[2]Program for Torture Victims, Los Angeles, California, USA

Over 111 nations currently sanction the use of or at least tacitly allow torture. The US, UK, and other "western" nations are not exempt. In the years since the terrorist attacks of 9/11, there has been increased political, media and professional attention to the topic of torture – what constitutes torture, circumstances under which it is allowable and not, and whether mental health and medical clinicians should be present during or participate in torture/interrogation proceedings. This attention became particularly dramatic during the media attention surrounding the events at the Abu Ghraib prison in Iraq and the Guantanamo Bay detention camp in Cuba. Narrow definitions have made the argument that certain techniques (such as "waterboarding") do not cause severe physical pain or lasting damage, and therefore are not torture. Related to these debates has been concern over medical and mental health complicity in torture (documented since the 1500s). Arguments in favor of clinician presence have included

"humanizing" and improving productivity of such proceedings. This panel presentation will discuss these issues from the perspective of trauma, mental health, and human rights. Current definitions of torture will be presented and the ethical statements of the various health and mental health professional organizations regarding torture will be discussed.

Delayed Onset PTSD: New Research on an Old Controversy

(Abstract #196022)

Symposium/Panel (Asses Dx, Res Meth) **Monroe Ballroom, 6th Floor**

Andrews, Bernice, PhD[1]; Brewin, Chris, PhD[2]; Engdahl, Brian, PhD[3]; Erbes, Christopher, PhD[3]; Winskowski, Ann Marie, MA[3]; Eberly, Raina, PhD[3]; Creamer, Mark, PhD[4]; Parslow, Ruth, PhD[4]; O'Donnell, Meaghan, PhD[4]

[1]Department of Psychology, Royal Holloway University of London, Egham, Surrey, United Kingdom
[2]Research Dept of Clinical Educational and Health Psychology, University College London, London, United Kingdom
[3]Psychology Section, US Department of Veterans Affairs Medical Center Minneapolis, Minneapolis, Minnesota, USA
[4]ACPMH, University of Melbourne, West Heidelberg, Victoria, Australia

Despite numerous studies since its inclusion in *DSM* there is little evidence of the mechanisms and predictors of delayed onset PTSD. This symposium brings together new findings on delayed onset posttraumatic stress disorder in the light of past controversy concerning its existence.

Risk Factors for Delayed Onset PTSD in UK Servicemen
Purpose: Due to definitional problems and small numbers in existing studies, there is scant knowledge of the causes of delayed onset PTSD. This retrospective study aimed to investigate differences in past psychiatric history, cognitive-affective factors and dissociative responses to trauma between groups reporting immediate and delayed onset PTSD. The role of life stress in contributing to delayed onset PTSD was also investigated.

Method: Retrospective in-depth interviews were conducted with 131 UK ex-servicemen in receipt of a war pension.

Findings: Compared to veterans with immediate onset, those with delayed onset were very similar to veterans with no PTSD in reporting lower levels of peritraumatic dissociation, guilt, and shame at the time of their main trauma. Veterans with delayed-onset PTSD were more likely to report severe life events and difficulties in the year before onset compared to veterans with no PTSD assessed in a comparable period. This effect could not be explained by events and difficulties caused by the veterans themselves, or by events of a traumatic nature.

Conclusions: Certain risk factors appear to be differentially involved in the onset of immediate and delayed PTSD.

The Development of Delayed Onset PTSD in UK Servicemen
Purpose: The delayed onset form of PTSD has often been regarded as controversial and there have been few detailed studies of it. Key questions for understanding the underlying mechanisms include whether the onset is typically sudden or insidious, and whether symptoms are acquired in any particular order.

Method: We conducted retrospective diagnostic interviews with a sample of UK ex-servicemen all in receipt of a war pension, dating individual traumatic events and PTSD symptoms. Reliability concerning the presence of individual symptoms was checked by interviewing a close other and varied according to the specific symptom.

Findings: Compared to a sample with immediate onset PTSD, the delayed group had already acquired more symptoms prior to their main trauma in service. A quarter of all PTSD cases acquired some symptoms prior to any trauma exposure. These were usually from the D cluster and can be attributed to training and routine military duties.

Conclusions: The findings indicate that delayed onset PTSD is the outcome of an insidious process that often lasts over a considerable time period.

The Onset of Post-War PTSD; Contrasts in Trauma Severity and Study Design
Purpose: to examine rates and predictors of delayed onset war-related PTSD.

Methods: We assessed two community samples of US war veterans: (1) POWS (n=262) retrospectively, 50+ years after their WWII service; (2) Iraq and Afghanistan war veterans prospectively, six and twelve months after their service (OEF/OIF; n=237). Liberal definitions of delayed PTSD were used: POWs had to remain below threshold for one year; OEF/OIF veterans had to exceed the cutoff at 12 months but not at 6.

Findings: Only 2 (1.9%) of the 140 lifetime POW PTSD cases were delayed onset. Twelve (42.8%) of the 28 OEF/OIF PTSD cases were delayed onset. OEF/OIF veterans reported lower PTSD rates than the POWs (11.8% vs. 53%), reflecting the POWs´ greater trauma exposure. Risk and resilience factors (age, education, social support, nonmilitary trauma exposure) predicted delayed onset only in the OEF/OIF group. In both groups nearly all "delayed onset" cases reported significant symptomatology prior to crossing diagnostic thresholds.

Conclusions: Delayed onset PTSD is commonly found in war veteran samples. Many contributing factors have been identified: the nature of the war itself, the society to which soldiers return, and study design. Our studies highlight the importance of trauma severity.

A Prospective Study of Delayed PTSD and Depression Following Traumatic Injury
Purpose: Delayed-onset PTSD is often characterised by subsyndromal diagnoses within the first 6 months (Carty, O´Donnell & Creamer, 2005). This prospective study aimed to identify factors other than pre-existing symptoms that contribute uniquely to the development of delayed-onset PTSD, as well as delayed onset depression.

Methods: A group of 826 injury survivors was assessed at 3 and 12 months postinjury. PTSD and depression were diagnosed according to *DSM-IV* criteria. Factors contributing to the development of delayed PTSD and depression were examined using logistic regressions. Variables of interest included demographic attributes, positive and negative social support, prior mental and physical health status, and personality attributes.

Findings: Of those with PTSD or depression at 12 months post-injury, around half had not met criteria at 3 months. Most of those with delayed onset reported earlier (including pre-trauma) mental health symptoms. Several non-health and personality measures were able to differentiate those with a chronic course from those with delayed onset.

Conclusions: Individuals who report some symptoms 3 months after trauma may still be at risk of developing the full disorder at a later stage. Identification of those at risk is crucial for effective service planning and early intervention.

Mental Health of War-Affected Youth in Two Conflicts: The Role of the Family, Community and Classroom

(Abstract #196389)

Symposium/Panel (Child, Civil Ref) **Salon 1, 3rd Floor**

Borisova, Ivelina, MED[1]; Betancourt, Theresa, SCD, MA[2]; Tol, Wietse, MA[3]; Komproe, Ivan, PhD[3]; Jordans, Mark, MA[4]; Vallipuram, Anavarathan, MBBS[5]; Sivayokan, S., MD[5]; de Jong, Joop, PhD[6]

[1]Harvard University, Cambridge, Massachusetts, USA
[2]Harvard University, Boston, Massachusetts, USA
[3]Public Health and Research, Healthnet TPO, Amsterdam, Netherlands
[4]Health Net TPO, Amsterdam, Netherlands
[5]Shanthiham, Association for Health and Counselling, Jaffna, Sri Lanka
[6]VU University Medical Center /Boston University School of Medicine, Amsterdam, Netherlands

The symposium examines war-affected youth in two different settings, including former child soldiers in Sierra Leone and youth in Sri Lanka. We present family and community factors in the post-conflict adjustment of child soldiers. We also discuss a classroom-based intervention model for war-affected youth in terms of its effectiveness and implications.

The Role of the Family in the Reintegration and Adjustment of Former Child Soldiers

Little is known about the role of the family in the post-conflict reintegration of children formerly associated with fighting forces (ex-CAFF). Existing Disarmament, Demobilization and Reintegration programs emphasize the family context as critical for the successful adjustment of former child soldiers. Evidence for the positive role of the family, however, is largely anecdotal and no specific protective factors in the family context have been identified (Wessells, 2006).The present study investigates the association between two relevant family factors and psychosocial outcomes in a sample of N=285 former child soldiers from Sierra Leone. In particular, the study focuses on 1) family placement of ex-CAFF (e.g. immediate, foster, kinship family), and 2) family economic resources and their direct and indirect impact on psychosocial adjustment. Structural equation modeling will be used to test the role of these family factors as mediators in the relationship between the latent constructs exposure to violence/trauma and psychological distress. Multi group analyses will explore possible differences between male and female ex-CAFF. Preliminary analyses suggest that economic resources are not associated with outcomes and that the direct and indirect impact of family placement differs by gender. Results are discussed in the context of reintegration programs for ex-CAFF.

The Impact of Stigma on the Reintegration and Adjustment of Former Child Soldiers

Research with former child soldiers has indicated that these youth often face significant stigma upon return to their communities. Although such responses complicate social reintegration, research is scant in terms of an in-depth exploration of stigma and its role in predicting psychosocial adjustment. This study used mixed methods to examine stigma as a predictor of psychosocial adjustment and social reintegration of male and female former child soldiers in Sierra Leone. Qualitative data was collected via focus group discussions with community members and individual interviews with former child combatants. Survey data was collected with N=285 youth. Qualitative and quantitative data indicate that despite sensitization programs that took place in many parts of Sierra Leone, many former child soldiers faced stigma and blame upon their return and many continue to feel stigmatized 2-3 years after reintegration. Qualitative data further describe some of the factors that may shape the way former child soldiers are accepted / perceived by their communities, and the ways in which youth cope with lack of acceptance. Survey data reveal that community stigma is a significant and independent predictor of psychological distress, controlling for the effects of war exposures/trauma, and that its impact is particularly strong among females.

Cluster Randomized Trial on a School-Based Intervention in War-Affected Northern Sri Lanka

A review of mental health treatments in low- and middle-income countries concluded that the evidence base for interventions in complex emergencies is weak (Patel et al, 2007). This study was aimed at evaluating treatment outcome of a school-based psychosocial intervention in war-affected Northern Sri Lanka. Children aged 8 to 12 years, in randomly selected schools, were screened for psychosocial distress with a screening checklist developed for the purpose (Jordans et al, under review). Selected children were assigned to a treatment (n=210) or waitlist condition (n=210). Children were assessed before, right after and four months after the intervention, using standardized symptom checklists and locally developed instrumentation addressing mental health and resilience constructs. Intervention consisted of a 5-week, 15-session manualized program that emphasizes integrating cognitive behavioral techniques with cooperative play and creative-expressive exercises (Macy et al, 2003).

Preliminary analyses on differences between baseline and first follow-up assessments, revealed the efficacy of the intervention with regards to function impairment, but not on specific mental health measures. Data collection for the second follow-up was being finalized at the time of writing. The presentation will address intervention and research implications of findings.

The Long-Term Consequences of Terrorism: Findings From Clinical and Population-Based Studies

(Abstract #196448)

Symposium/Panel (Disaster, Sos Ethic) **Salons 4-6, 3rd Floor**

Silver, Roxane C., PhD[1]; Neria, Yuval, PhD[2]; Holman, E. Alison, PhD, FNP[3]; Gil-Rivas, Virginia, PhD[4]; Poulin, Michael, PhD[5]; *Naturale, April, MSW, LCSW, ACSW*[6]

[1]University of California, Irvine, Irvine, California, USA
[2]Department of Psychiatry, Columbia University Medical Center, New York, New York, USA
[3]Program in Nursing Science, University of California Irvine, Irvine, California, USA
[4]University of North Carolina at Charlotte, Charlotte, North Carolina, USA
[5]Center for Behavioral and Decision Sciences in Medicine, University of Michigan, Ann Arbor, Michigan, USA
[6]Disaster Mental Health Management and Training; Supervision and Private Practice, Montclair, New Jersey, USA

Terrorism seriously threatens mental and physical health around the world. In this panel, distinguished researchers and clinicians will discuss findings from longitudinal studies of high-risk clinical patients and national population-based samples addressing a range of long-term mental, health, social and political consequences of terrorism.

The Long-Term Sequelae of Terrorism: PTSD Trajectories in the First Five Years After the 9/11 Attacks

The attacks of September 11, 2001 resulted in high rates of PTSD in the general population followed by a significant decline over time. Little information exists on the long-term effects of 9/11 in high-risk clinical populations. We will present findings from a longitudinal study on the long-term course of 9/11-related PTSD, along with its determinants and clinical correlates, among a prospective cohort of 455 patients, mostly minority and poor, interviewed one and five years after-9/11, from a large primary care practice in New York City. The presentation will focus on: 1) trajectories of 9/11 PTSD; 2) risk factors for early and late onset of 9/11 related PTSD; and 2) associations between PTSD trajectories and a range of well ascertained medical comorbidities, psychiatric disorders, suicidality measures, functional impairments and measures of disability, while taking into account detailed data on previous physical and mental health problems and trauma history

before and during the attacks of 9/11. Our findings will highlight the specific long-term health and mental health care needs associated with post-disaster psychopathology among this high risk population and will underscore the importance of developing post-trauma professional care, including screening and treatment capacities from general medical settings who are exposed to trauma.

Early Predictors of Long-Term Health Status and Utilization Following the 9/11 Terrorist Attacks
The September 11th terrorist attacks exposed United States residents to an extraordinary collective stress and presented a unique opportunity to examine their impact on health over time. Using a national probability sample, we examined the relationships among acute stress responses to the terrorist attacks, physical ailments, functioning, and health care utilization over three years following the attacks. High 9/11-related acute stress predicted increased incidence of non-cardiovascular physical health ailments, utilization of health care services, and poorer functioning over the 3 years following 9/11. After adjusting for demographics, smoking status, BMI, pre-9/11 mental and physical health, lifetime and post-9/11 stress, and exposure to the attacks, acute stress remained a significant predictor of functional impairment over time. Lifetime stress was associated with increased incidence of physical ailments; post-9/11 stress was associated with utilization and functional impairment. Cardiovascular and musculoskeletal ailments were associated with poorer functioning in the years following the attacks. Using health data collected prior to 9/11/01 as a baseline, acute stress response to the 9/11 attacks predicted increased reports of physician-diagnosed non-cardiovascular ailments and poorer functioning over three years following the attacks.

The Social Context of Coping With Ongoing Threat and Well-Being Following the 9/11 Terrorist Attacks
In the aftermath of trauma and in the face of ongoing threats of terrorism, people often turn to those close to them to express their fears and concerns and to obtain support. Utilizing data from a national adult sample assessed shortly after the terrorist attacks of September 11th and re-assessed annually for 3 years following the attacks, we will discuss the role of the social environment (e.g., support, conflict, constraints) on individuals´ well-being (i.e., psychological distress, positive affect, and life satisfaction) over time. Results indicate that the responses of important social contacts (e.g., partners, family members, and friends) may moderate the impact of fears of future terrorism on individuals´ well-being when individuals attempt to disclose their concerns about future attacks to others. The extent to which unsupportive social responses negatively affect well-being depends on the overall quality (i.e., support and conflict) of these relationships. However, in the context of supportive relationships, constraints on individuals´ attempts to talk about their fears may not interfere with respondents´ efforts to successfully manage them. The implications of these findings for research, prevention and intervention will be discussed.

Societal and Political Outcomes of 9/11: 9/11-Related Distress and Support for Aggressive U.S. Policies
Several years since 9/11, many people still report low levels of 9/11-related posttraumatic stress (PTS) symptoms, especially in the form of re-experiencing thoughts about the attacks. While these symptoms are often subclinical, they may nonetheless have broader societal implications. In particular, levels of PTS, by making the 9/11 attacks chronically salient, may influence support for U.S. policies related to terrorism. This possibility was examined in a longitudinal survey of a nationally representative sample of the U.S. population (N = 1613) assessed in late 2006 and again in late 2007. Results at Wave 1 (Dec. 2006-Jan. 2007) indicated that 9/11-related re-experiencing was associated with greater support for aggressive action against terrorism, greater support for the Iraq war, and greater willingness to sacrifice civil liberties. Findings at Wave 2 (Dec. 2007-Jan. 2008) indicated that 9/11-related re-experiencing was associated with greater support for the Iraq war, greater willingness to sacrifice civil liberties, and greater support for the use of torture, even controlling for Wave 1 support for similar policies. Low levels of personal-level distress may shape citizens' support for national-level policies. Potential implications and emotional mechanisms of this phenomenon will be discussed.

When Violent Behavior is the Etiological Stressor: Psychotherapy as Future Violence Prevention

(Abstract #196421)

Symposium/Panel (Practice, Sos Ethic) **Salons 7-9, 3rd Floor**

Lipke, Howard, PhD[1]; **MacNair, Rachel, PhD**[2]
[1]*Staff Psychologist/PTSD team leader, North Chicago DVA Medical Center, Wheeling, Illinois, USA*
[2]*Director, Institute for Integrated Social Analysis, Kansas City, Missouri, USA*

When traumatization itself causes re-traumatizing behavior, therapy has wider social implications than helping individuals. When violent behavior was the trauma, subsequent violent behavior becomes more likely, and a cycle of traumatization persists. When understanding psychological explanations for this, we can better design helpful interventions.

Clinical Psychology: Guilt and Subsequent Destructive Behavior
The emotion primarily associated with the destructive psychological effects of traumatic events is fear. Nonetheless clinical experience demonstrates that other emotions, notably debilitating guilt, caused by sanctioned or unsanctioned behavior, is also a profoundly important effect of traumatic exposure. While guilt is sometimes held to be essential to preventing destructive behavior, it is proposed here that guilt in its debilitating form is more likely to lead to further destructive behavior than to prevent it. Addressing guilt from a scientific psychotherapeutic perspective, especially over one of the most extreme of human behaviors, killing, cannot be done without simultaneously addressing moral questions. Additionally, even if it is decided that treatment is to be provided, there are problems which must be overcome, including confidentiality, re-traumatization, and finding possible paths to resolution. This presentation will address ethical issues involved in treating debilitating guilt, especially over extreme behavior, including killing, then describe how a particular method of psychotherapy, EMDR, in its integration of cognitive therapy with its unique aspects, lends itself to overcoming barriers to effective treatment in this area.

Social Psychology: Post-Trauma Symptoms and Causation of Violence
Post-trauma symptomatology can lead directly to outbursts of violence in crime and domestic abuse through sleep disturbance, hostile outbursts, flashback-induced misidentifications and other dissociative confusions, and trauma addiction. These suggestions from forensic psychology demonstrate the potential for individual unplanned violence. Symptoms can also cause or exacerbate violence planned by groups. Emotional numbing, estrangement from others, avoidance, and outbursts feed into several social psychology theories on causation of violence: Bandura´s mechanisms of moral disengagement, especially dehumanization of victims; Milgram´s findings on obeying destructive demand of authorities; and over-simplification and rigidity of decision-making, including groupthink. These underscore the need for symptom reduction for subsequent violence reduction.

Distinctive therapeutic needs must taken into account. Studies suggest prolonged exposure is counter-indicated. Knowledge of symptoms as a common reaction, rather than being “crazy,” can help, along with a knowledge of different symptom patterns observed compared to other stressors. Other possibilities are traditions of atonement, bearing witness, and EMDR techniques (covered by the first speaker).

Combining CBT With a Social Support Intervention for Treating PTSD: Results of a Randomized Study

(Abstract #196523)

Paper Presentation (Clin Res, Practice) **Salons 7-9, 3rd Floor**

Guay, Stephane, PhD[1]; Marchand, Andre, PhD[2]
[1]Criminology, Université de Montréal, Montreal, Quebec, Canada
[2]Psychology, Université du Québec à Montréal, Montreal, Quebec, Canada

Given the strong links between social support and PTSD, psychotherapies that integrate social interventions should be developed. Our goal was to explore the efficacy of cognitive-behavioral therapy (CBT) with a spousal supportive component (CBT-Sup) in treating patients with PTSD by comparing its effect to an individual CBT (CBT-Ind). Forty-six civilians with a diagnosis of PTSD (based on a SCID-I assessment) were randomly assigned to one of the two treatment conditions. In both conditions, participants received between 16 and 20 sessions of CBT. In CBT-Sup, an additional intervention with the spouse consisted of 3 sessions on psychoeduction about PTSD, rational of CBT and ways to increase supportive interactions. PTSD, depression and anxiety symptoms were measured as dependent variables. Our results at posttreatment indicated that participants in CBT-Sup had significantly better outcomes regarding PTSD symptoms severity compared to CBT-Ind in both study completers ($F=6.25$, $p<.02$) and intent-to-treat samples ($F=6.23$, $p<.02$). Similar but non significant trends were found for depression and anxiety symptoms. Overall, our findings suggest that adding social support interventions with the spouse to individual CBT in treating PTSD may lead to better outcomes. Six-month follow-up data and future directions for research will be presented/discussed.

The Role of PTSD in Violence, Arrest and Treatment Engagement Among People With SMI

(Abstract #196158)

Paper Presentation (Clin Res, Sos Ethic) **Salons 7-9, 3rd Floor**

Cusack, Karen, PhD[1]; Elbogen, Eric, PhD[2]; Swanson, Jeffrey, PhD[3]; Swartz, Marvin, MD[4]
[1]University of North Carolina at Chapel Hill, Chapel Hill, North Carolina, USA
[2]University of North Carolina, Chapel Hill, North Carolina, USA
[3]Duke University Medical Center, Durham, North Carolina, USA
[4]Duke University, Durham, North Carolina, USA

PTSD is associated with a range of negative outcomes among people with serious mental illness (SMI) including more severe mental health, physical health, and substance abuse symptoms and more frequent hospitalization. Although PTSD is associated with violence and arrest among combat veterans, it has received insufficient attention as a potential risk factor for criminal behavior among people with SMI. The current study tested the hypothesis that PTSD is associated with an increased risk of violence, arrest, and poor treatment engagement among people with SMI. The study was based on secondary analysis of cross-sectional data on 954 people recruited from community mental health centers. Logistic regression models were used to control for relevant demographic and clinical factors. Substance abuse, history of childhood abuse and PTSD severity each contributed to the likelihood of violence in the past year. PTSD was not associated with the probability of having been arrested in the past year. As predicted, PTSD severity was strongly associated with poor treatment engagement. These findings suggest that PTSD should be considered among the risk factors for violence among people with SMI, and that greater efforts to engage these individuals in treatment may be needed.

Papers
Complex PTSD in Children

Salon 3, 3rd Floor

Chair: Wendy Taylor, MA,
University of Michigan, Ann Arbor, Michigan USA

Childhood Emotional Abuse as a Predictor of Adverse Outcomes: Results From a Meta-Analysis

(Abstract #196516)

Paper Presentation (Asses Dx, Prev El)

Taylor, Wendy, MA[1]; Polli, Frida, PhD[2]; Spinazzola, Joseph, PhD[3]; van der Kolk, Bessel, MD[4]
[1]University of Michigan, Ann Arbor, Michigan, USA
[2]M.I.T., Charlestown, Massachusetts, USA
[3]Boston University, Brookline, Massachusetts, USA
[4]Boston University, Boston, Massachusetts, USA

Though childhood emotional abuse appears to be the most common form of childhood maltreatment and a focus of clinical concern, most research to date has focused on harm resulting from childhood sexual and physical abuse. However, it is unclear whether the impact of different forms of abuse have distinct or equally severe outcomes. The goal of this study was to quantitatively summarize the data from over 100 studies to answer the following questions: 1) Is there a detrimental long-term impact of experiencing only childhood emotional abuse? and 2) How does the long-term impact of childhood emotional abuse compare to the impact of childhood sexual or physical abuse? In the community studies we explored, we found that 1) emotional abuse was the most common form of abuse and occurred in 11-65% of participants, and was associated with a broad range of adverse outcomes; 2) emotional abuse was associated with equally severe outcomes compared to physical and sexual abuse in over half of the studies, and 3) emotional abuse moderates between physical abuse and outcome severity. Methodological issues, meta-analytic findings and effect sizes are reported and discussed.

Posttraumatic Stress Symptoms in Children and Adolescents Receiving Child Welfare Services

(Abstract #196172)

Paper Presentation (Child, Clin Res)

Kolko, David, PhD[1]; Hurlburt, Michael, PhD[2]; Zhang, Jinjin, MS[2]; Barth, Richard, PhD[3]; Leslie, Laurel, MD[4]; Burns, Barbara, PhD[5]
[1]University of Pittsburgh School of Medicine/WPIC, Pittsburgh, Pennsylvania, USA
[2]Child and Adolescent Services Research Center, San Diego, California, USA
[3]University of Maryland School of Social Work, Baltimore, Maryland, USA
[4]Tufts Medical Center, Boston, Massachusetts, USA
[5]Duke University, Durham, North Carolina, USA

This study reports the prevalence of and contributors to heightened posttraumatic stress (PTS) symptoms in the first nationally representative sample of children and adolescents served by the child welfare system who resided in in-home care (IHC) or out-of-home care (OHC). The children (N = 1,848; ages 8 – 14) completed the Posttraumatic Stress Scale from the Trauma Symptom Checklist for Children upon study intake. The prevalence of clinically significant PTS symptoms was 11.7%, with higher rates reported for OHC than IHC (19.2% vs. 10.7%). Children (vs. adolescents) reported a higher rate of PTS in IHC, but not in OHC. There were unique contributors to heightened PTS symptoms in children (e.g., perpetrator was biological parent) and adolescents (e.g., referral for emotional abuse), but family violence exposure and victimization were robust contributors in both age subgroups. Hierarchical regression identified contributors to heightened PTS symptoms from different domains. We also found

a four-fold increase in heightened PTS symptoms when abuse was committed by a non-parent as compared to a biological parent, but no such relationship was found among neglected children. The findings extend our understanding of the nature of clinically significant levels of PTS symptoms in children and youth receiving child welfare services and their treatment needs.

Childhood Trauma, Poverty, and Adult Victimization: An Application of Multilevel Modeling

(Abstract #195902)

Paper Presentation (Prev El, Res Meth)

Klest, Bridget, MA[1]
[1]*Psychology, University of Oregon, Eugene, Oregon, USA*

This paper employs multilevel modeling to examine whether poverty rates within communities impact relationships between childhood trauma, dissociation, and adult victimization within individuals. A sample of 421 homeowners from five communities was surveyed for childhood trauma exposure, dissociative experiences, and victimization in adulthood. Community poverty rates were assessed using U.S. census data. The results of this study suggest that childhood victimization and dissociation each uniquely predict variance in adult victimization, some variance in adult victimization is attributable to community-level variables, and social context affects revictimization. In particular, the relationship between childhood trauma and victimization in adulthood tends to be stronger among individuals in communities with higher poverty rates. Efforts targeting people victimized as children who currently live in poorer communities might have great potential for reducing revictimization. This study provides an example of the ways in which multilevel designs permit researchers to ask more complex questions, impacting our understanding of the causes, consequences, and prevention of trauma.

Terror and Trauma for Homeless and Prostituted Street Youth: How Can Societal Response be Improved?

(Abstract #196020)

Paper Presentation (Child, Commun)

Williams, Linda M., PhD[1]
[1]*Criminal Justice and Criminology, University of Massachusetts Lowell, Lowell, Massachusetts, USA*

This paper will report findings from in-depth narratives of and research interviews with homeless, runaway and sexually victimized (prostituted and trafficked) teens in the United States. Research participants are teens (14-19 years of age) interviewed in the U.S. in two large urban areas—Boston, MA and Washington DC. Narratives from homeless and prostituted runaway youth (100 males and females) and focus groups with young adult survivors form the basis of the paper. The research focuses on understanding the victims´ perspectives. New findings will be presented on trauma confronted by street youth (including abandonment, sexual exploitation, and physical violence) and appraisal of the resources needed by and provided to traumatized youth who are not living in "traditional" families. This paper will provide information to practice and policy communities to increase the safety and well being of street youth and make recommendations for service providers.

Papers
Journalism and Vicarious Traumatization

Wabash Room, 3rd Floor

Chair: Marina Ajdukovic, PhD,
Department of Social Work, University of Zagreb, Zagreb, Croatia

Secondary Trauma in Journalism: A Critical Ethnographic Study

(Abstract #196569)

Paper Presentation (Media Ed, Prev El)

Keats, Patrice, PhD[1]**; Buchanan, Marla, PhD**[2]
[1]*Education, Simon Fraser University, Burnaby, British Columbia, Canada*
[2]*Educ and Counselling Psych and Special Educ, University of British Columbia, Vancouver, British Columbia, Canada*

We will discuss the findings of a research project investigating secondary traumatization of Canadian journalists and photojournalists. This ethnographic study includes in-depth interviews, observations, and focus group discussions with journalists across Canada. Our primary aim is to understand the beliefs, shared meanings, and occupational practices of workers from the journalism field in the context of trauma and disaster events that put them at risk of assignment stress injuries from witnessing trauma (e.g., depression, posttraumatic stress, anxiety). We documented the experiences of a diverse group of 30 Canadian journalists who were at risk for developing traumatic stress symptoms from their work with trauma survivors in local, national, and international trauma, conflict, or disaster events. We explore the consequences of their exposure to traumatized populations to understand the context specific conditions underlying their work related stress. This includes understanding the contextual impact of traumatic events, their consequences, and journalists´ approaches to coping during the event, in the newsroom, and in their personal lives. These findings have contributed to our understanding of the use and type of psychological support available for news workers both in and out of the newsroom.

Case Study of Vicarious Traumatization of Field Researchers of Trauma

(Abstract #196056)

Paper Presentation (Clin Res, Prev El)

Ajdukovic, Marina, PhD[1]
[1]*Department of Social Work, University of Zagreb, Zagreb, Croatia*

During the war in the Balkans substantial parts of the population experienced traumatic events and many still suffer consequences. A number of them neither seek nor receive mental health assistance. Within the major international project CONNECT, that was carried out to increase understanding of long term impact of traumatization on population mental health and their treatment seeking behavior, a group of researchers were intensively engaged in field work. The impact of several months' long intensive involvement in organizing, recruiting and interviewing traumatizes individuals on mental health of field researchers will be presented. Regardless of good organizational support, they showed signs of chronic fatigue, increased conflicts in the team and more frequent health difficulties. The meetings with an experienced outside supervisor revealed that these were related to vicarious traumatization. The recommendation for trauma-related supervision for field researchers will be presented, i.e. psychoeducation about secondary traumatisation, debriefing and prevention of vicarious traumatization. Suggestions how to balance mental health needs of researchers in the field of trauma, the financial costs and efficiency will be discussed.

A Comparative Analysis of Clinical and Administrative Occupational Stress in VA Health Care Workers

(Abstract #195707)

Paper Presentation (Practice, Mil Emer)

Newell, Jason, PhD[1]; Davis, Lori, MD[2]
[1]Veterans Affairs Medical Center, Tuscaloosa, Alabama, USA
[2]Research and Development, Tuscaloosa VA Medical Center, Tuscaloosa, Alabama, USA

This paper presents the results of data examining the differences in the experience of professional burnout, secondary traumatic stress, compassion fatigue, and compassion satisfaction in a group of VA mental health care professionals when compared to a group of administrative (non-clinical) service providers.

Analysis of burnout data revealed that over 60% of employees in both the administrative and the clinical groups experienced moderate to high levels of emotional exhaustion. Significant differences in emotional exhaustion scores were noted based on gender and race. Administrative staff were found to have a lower sense of personal accomplishment than clinical providers. Professional experience was found to be a significant predictor of depersonalization toward clients and their situations. Overall, participants in both groups (94%) scored high on the measure of compassion satisfaction; however, symptoms of compassion fatigue were also noted in both groups. Little to no indication of secondary traumatic stress was found in either sample, despite that fact the veterans are known to have a higher rate of trauma exposure.

The Lingering Effects of Trauma: Bedouin Wives and Mothers of Men Serving in Israel's Defense Forces

(Abstract #195868)

Paper Presentation (Cul Div, Asses Dx)

Caspi, Yael, SCD, MPH, MA[1]; Shorer, Shai, MA[2]; Klein, Ehud, MD[1]
[1]Psychiatry, Rambam Medical Center, Haifa, Israel
[2]School of Social Work, University of Haifa, Haifa, Israel

The vicarious impact of trauma on professionals caring for survivors has been well described. The fewer studies of the effect on immediate family identified increased caregiver burden and poorer psychological adjustment in wives of traumatized veterans with PTSD. The suitability of 'secondary traumatization' in non-Western groups has not been studied. This presentation describes findings from community-based interviews with 67 mothers and 129 wives connected with 221 Bedouin soldiers and veterans in Israel's Defense Forces. More husbands than sons were suffering from PTSD and other DSM diagnoses (¯2=7.24 df=2 p<.05), yet trauma was prevalent even among those with no diagnosis. Separate multiple hierarchical linear regression analyses indicated that while husbands' PTSD was highly associated with wives' depression and PTSD scores and family's ability to work out problems, sons' psychiatric status was not a predictor of mothers' emotional wellbeing, but rather mothers' financial status, adverse life events and sons' angry outbursts. Additional findings further discuss differences between wives and mothers and propose a conceptual framework for the impact of living with men suffering from trauma-related disorders on traditional non-Western families.

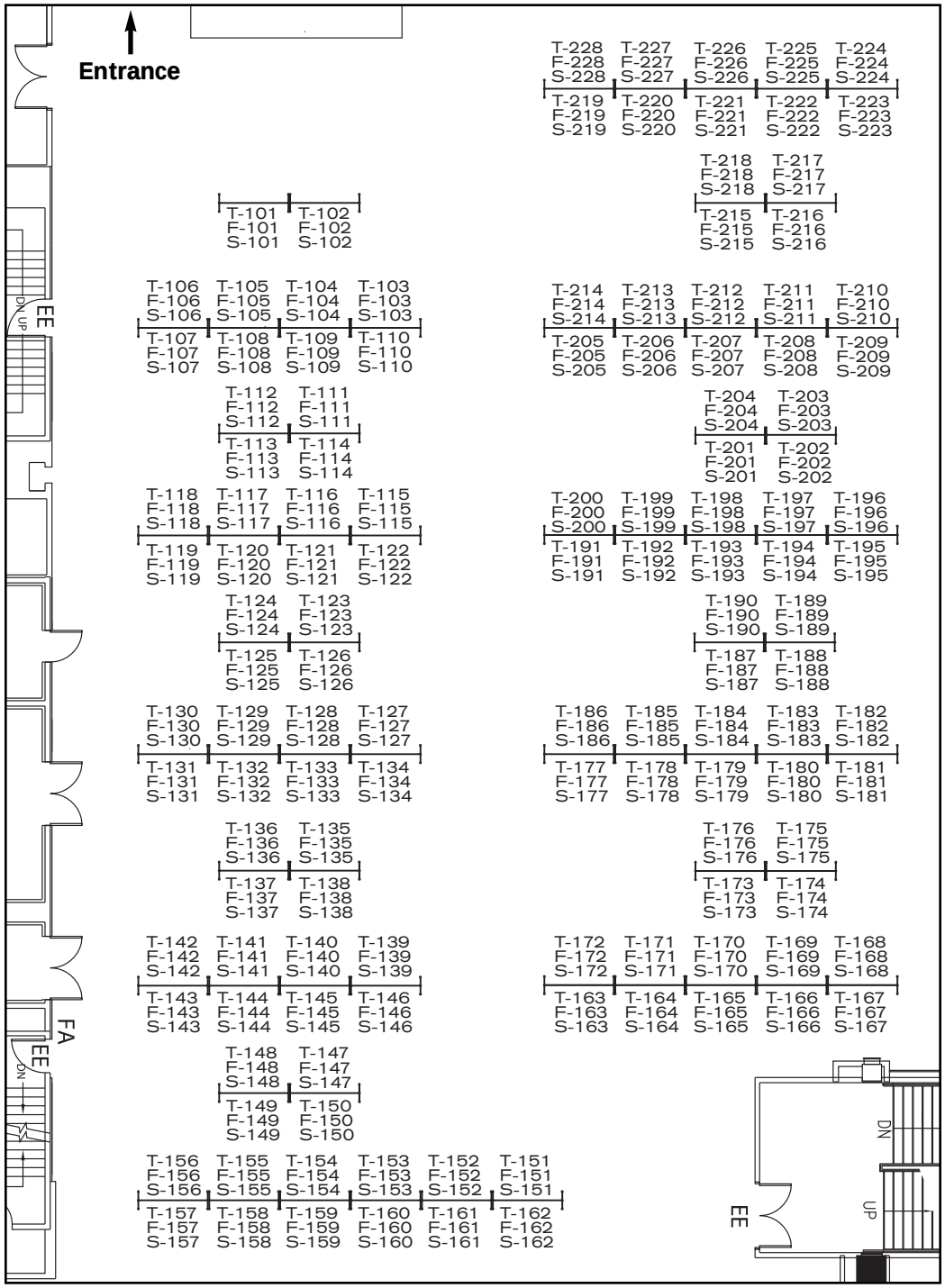
Terror and its Aftermath
24th ISTSS Annual Meeting

November 13-15, 2008
(with Pre-Meeting Institutes Nov. 12)
The Palmer House Hilton • Exhibition Hall, 4th Floor

Session 1: Thursday, November 13	
Poster Set-up:	7:30 a.m. – 9:30 a.m.
Poster Display:	9:30 a.m. – 6:00 p.m.
Poster Presentation:	5:00 p.m. – 6:00 p.m.
Poster Dismantle:	6:00 p.m.

Session 2: Friday, November 14	
Poster Set-up:	7:30 a.m. – 9:30 a.m.
Poster Display:	9:30 a.m. – 6:00 p.m.
Poster Presentation:	5:00 p.m. – 6:00 p.m.
Poster Dismantle:	6:00 p.m.

Session 3: Saturday, November 15	
Poster Set-up:	7:30 a.m. – 9:30 a.m.
Poster Display:	9:30 a.m. – 6:00 p.m.
Poster Presentation:	5:00 p.m. – 6:00 p.m.
Poster Dismantle:	6:00 p.m.



Poster Dismantle

Immediately following your scheduled poster session, display materials must be taken down and removed. Items not removed by the appointed poster dismantle time will be disposed of and are not the responsibility of ISTSS.

Session 1: Thursday, November 13
Exhibition Hall, 4th Floor

Poster Organization

Each poster is scheduled for either Poster Session 1 on Thursday, Poster Session 2 on Friday or Poster Session 3 on Saturday. Each session includes a one-hour time period where the presenting author is available to answer questions.

Posters are organized within the final program by presentation day, and then by track within each day. The presenting author is underlined. In addition, the index provided at the back of the final program includes all of the authors. A floor map showing the layout of posters is available in the poster hall and is available on page 160.

Session 1: Thursday, November 13
Exhibition Hall, 4th Floor

Poster Set-Up:	7:30 a.m. – 9:30 a.m.
Poster Display:	9:30 a.m. – 6:00 p.m.
Poster Presentation:	5:00 p.m. – 6:00 p.m.
Poster Dismantle:	6:00 p.m.

Poster Dismantle

Immediately following your scheduled poster session, display materials must be taken down and removed. Items not removed by the appointed poster dismantle time **will be disposed** of and are not the responsibility of ISTSS.

Tracks

Posters will be presented on a wide variety of topics indicating track:

1. Assessment/Diagnosis (Assess Dx)
2. Biological/Medical (Bio Med)
3. Children and Adolescents (Child)
4. Civilians in War/Refugees (Civil Ref)
5. Clinical or Interventions Research (Clin Res)
6. Clinical Practice Issues (Practice)
7. Community Programs (Commun)
8. Culture/Diversity (Cul Div)
9. Disaster/Mass Trauma (Disaster)
10. Media/Training/Education (Media Ed)
11. Military/Emergency Services/Aid workers (Mil Emer)
12. Prevention/Early Intervention (Prev EI)
13. Research Methodology (Res Meth)
14. Social Issues/Public Policy/Ethics (Soc Ethic)

Crisis Debriefing Following Child Fatality: The Restoring Resiliency Response Model

(Abstract #200646)

Poster T-101 (Disaster, Practice) **Exhibition Hall, 4th Floor**

Pulido, Mary, PhD[1]
The New York Society for the Prevention of Cruelty to Children, New York, New York, USA

Child Protective Service (CPS) workers have extraordinarily difficult and demanding jobs. As "first responders" to cases of severe child abuse, support systems, such as crisis debriefing, must be incorporated into standard procedures in order to reduce the excessive stress resulting from child fatalities, severe cases of physical and sexual abuse and violence in the field and/or workplace. In New York City, the Restoring Resiliency Response (RRR) model has been utilized by Child Protective Services to alleviate the stress and anxiety associated with these issues. This model differs from classical critical incident stress debriefing, in that it does not have an investigatory stance requiring staff to retell the incident. The primary goal of these sessions is to mitigate the impact of the critical incident and to accelerate the recovery process. Focus is placed on the individual's ability to utilize support systems and past coping techniques. These sessions integrate education, emotional expression and cognitive restructuring. They also aim to enhance group cohesion and unit performance. This seminar will cover the process of developing a debriefing model to meet CPS needs; how to utilize the RRR protocol following a traumatic event, and techniques used in the sessions to reduce Post Traumatic Stress Symptoms.

Secondary Traumatic Stress in Post-Katrina Responders in New Orleans

(Abstract #200647)

Poster T-102 (Disaster, Practice) **Exhibition Hall, 4th Floor**

Naturale, April, MSW, LCSW, ACSW[1]
[1]*Psychology Beyond Borders, Montclair, New Jersey, USA*

The size and physical devastation of Katrina make it the most destructive and costliest (75 billion) natural disaster in the history of the United States and one of the deadliest. The storm surge that caused several breaches in the levees protecting the city of New Orleans and flooding 80% of New Orleans with 20 to 25 foot deep waters created a humanitarian crisis as those without the means or the health to evacuate were caught in the storm. Law enforcement and rescue staffs assisted and forcibly removed those who would not or could not flee, as conditions were dangerous and uninhabitable. Additionally, staffs working in other public service areas were called to assist with evacuation, shelter management and mental health support to vulnerable populations. Many of these staffs were unprepared for the level and intensity of exposure to the distress of survivors especially since many were victims themselves. Some suffered with secondary traumatic stress responses as a result of their work and required intervention to be able to return to a functional level of personal and professional activities. Case examples of the extraordinary public servants will be presented and the need to prepare for addressing such affects will be discussed.

Examining STS in Social Work Students Working in Post-Hurricane Louisiana

(Abstract #200648)

Poster T-103 (Disaster, Practice) **Exhibition Hall, 4th Floor**

Seyle, Conor, PhD[1]
[1]*Psychology Beyond Borders, Austin, Texas, USA*

This study tracked rates of secondary traumatic stress symptoms in a class of graduating Masters of Social Work students who had been working with people affected by Hurricanes Katrina and Rita in Louisiana (85F, 6M, mean age =29.03; 70.5% Caucasian, 22.1% African-American). As a part of a workshop on the potential impacts of working with traumatized populations, these participants completed measures including the PTSD checklist (PCL-C) and STS measures (PROQol R-IV). Participants also completed several open-ended questions asking them to describe their experiences with the hurricanes, which were analyzed using computer linguistic analysis programs. Analyses suggest that this population showed rates of STS symptoms comparable to those found in other helper populations with the exception of the "burnout" factor, which was particularly low. Regression analyses found that age and income predicted scores on the outcome measure, with income predicting reduced compassion satisfaction and increased burnout and age predicting higher levels of compassion fatigue. Linguistic analyses of the participant's writing found that those participants who used more tentative language showed lower rates of PTSD symptoms, marginally more compassion satisfaction, less burnout, and less compassion fatigue.

Quality of Life in Torture Survivors in Kashmir: A Six-Year Follow Up

(Abstract #193908)

Poster # T-104 (Civil Ref, Cul Div) **Exhibition Hall, 4th Floor**

Ali, Zaffar, MBBS, DPM, DNB, MD[1]; Margoob, Mushtaq, MD[2]

[1]Psychiatry 00MH, J J Peters Veterans Affairs Medical Center, Bronx, New York, USA

[2]Psychiatry, Government Hospital for Psychiatric Disease, Srinagar, Jammu and Kashmir, India

Torture victims suffer from particularly debilitating psychological stress with resultant PTSD and a variety of physical disabilities. This report describes the changes in QOL in a group of torture survivors who were administered several rating scales in 2001 including the CAPS and a quality of life (QOL) scale as part of a larger sample. The authors were able to contact 36 patients out of the original cohort and their QOL was reassessed 6 years after the original evaluation. The sample was exclusively male and the mean duration of illness was 112 months. 78% of the sample continued to suffer from significant psychosocial dysfunction. Scores on the interpersonal relationship and instrumental role domains were virtually unchanged with small but significant decreases in Intrapsychic functioning domain scores. The QOL scores were minimally better when compared to a control group of patients with Schizophrenia. Physical disability scores were not notably high in this group and their contribution to QOL scores was minimal. Torture causes a huge burden of illness on its sufferers and a multi-disciplinary treatment approach adapted to local cultural norms seems to be essential.

Warriors in Transition: Consequences and Impact of Demands for Army Community Service Intervention

(Abstract #193942)

Poster # T-105 (Ethics, Mil Emer) **Exhibition Hall, 4th Floor**

Jenkins Jr, Charles T., MSW[1]

[1]Department of the Army, Army Community Service, Fort Sill, Oklahoma, USA

All too often Soldiers and Family Members are faced with unexpected crises and life changes. When this occur the Family system is understandably psychosocially impaired and becomes maladaptive to the social ills and burdens placed on the entire family system. Experience to date suggests that a Warrior in Transition is challenged with overcoming many new and different life obstacles.

The Iraqi war results, in comparison to the Persian Gulf Conflict, has an outcome much different, greater and more traumatic than what we experienced after the Persian Gulf. On the other hand, Army Family Programs have made many adjustments and modifications of programs and services for Soldiers and Family Members. What we now see in ACS Army Wide is a more complex and sophisticated body of programs and services, and a well informed customer who in many instances comes with a clear understanding of the presenting problem.

Resilience: Do You Need it? Do You Have it?

(Abstract #194056)

Poster # T-106 (Practice, Media Ed) **Exhibition Hall, 4th Floor**

Charlton, Margaret, PhD[1]

[1]Intercept Center, Aurora Mental Health Center, Aurora, Colorado, USA

Terror has a secondary impact that we often ignore. When therapists work with victims of trauma, that trauma also affects the therapists. Vicarious or secondary trauma can produce the same type of symptoms and disruption of functioning for clinicians as primary trauma does for our clients. Vicarious trauma is also a major contributor to burn out for clinicians practicing in this field. Therefore it is vitally important that clinicians, supervisors and administrators learn to recognize symptoms of vicarious trauma, develop resilience, and implement strategies to manage clinical exposure to trauma.

Shared Traumatic Stress in Manhattan Clinicians and the Post 9/11 Quality of Professional Practice

(Abstract #200650)

Poster T-107 (Disaster, Practice) **Exhibition Hall, 4th Floor**

Tosone, Carol, PhD[1]

[1]New York University, New York, New York, USA

This paper presents the results of the Post 9/11 Quality of Professional Practice Survey (PQPPS) which explored the long-term impact of 9/11 on clinicians practicing and/or residing in Manhattan. A total of 481 clinical social workers members of the Manhattan chapter of NASW(38% response rate) replied to the PQPPS mail survey. Shared traumatic stress was measured by the multiplication of scores for the PCL-C and Pro-QOL (CF/STS subscale). On a bivariate level, shared traumatic stress was positively correlated With compassion fatigue (p<.0001), ambivalent attachment (p<.0001), avoidant attachment (p<.0001), traumatic life events (p<.0001), posttraumatic stress (p<.0001), perception of the likelihood of another 9/11 event within two years (p=.0004), and being currently affected by the events of 9/11 (p<.0001). It was negatively associated with compassion satisfaction (p=.0166), resiliency (p<.0001), years in the field (p=.0344), institute training (p=.0041), and life change due to the events of 9/11 (p<.0001). On a multivariate level controlling for 21 variables, only compassion fatigue (p<.0001) and posttraumatic stress (p<.0001) were significant predictors of shared traumatic stress.The concept of shared traumatic stress captures the experience of clinicians practicing in a traumatological environment while simultaneously facing the same issue in their personal lives.

Poster T-108 (withdrawn)

The Relationship Between Dissociation and Anger Among Combat Veterans With PTSD

(Abstract #195212)

Poster # T-109 (Mil Emer, Clin Res) **Exhibition Hall, 4th Floor**

Kulkarni, Madhur, M.S.[1]; Porter, Katherine, M.S.[2]; Rauch, Sheila, PhD[3]; Favorite, Todd, PhD[4]; Martis, Brian, MD[4]; Defever, Erin, BA[5]

[1]Psychology, University of Michigan, Ann Arbor, Michigan, USA

[2]Eastern Michigan University, Ypsilanti, Michigan, USA

[3]University of Michigan, Ann Arbor, Michigan, USA

[4]Psychiatry, University of Michigan/ VAAAHCS, Ann Arbor, Michigan, USA

[5]VA Ann Arbor Healthcare System, Ann Arbor, Michigan, USA

Prior research on traumatized populations suggests that dissociation and anger are risk factors for the development of posttraumatic stress disorder (PTSD). Research has shown that trauma survivors with higher levels of anger also report more severe PTSD overall. Studies also support a relationship between PTSD severity and dissociation. Only one study of sexual assault survivors by Feeny, Zoellner, and Foa (2000) examined the relationships between dissociation, anger, and PTSD, and found that higher levels of anger and dissociation predicted worse outcomes at 3-months post-assault. While veterans report high levels of anger and dissociation (e.g., Novaco & Chemtob, 2002), the relationship between these factors and PTSD has not been examined among veterans. This poster will examine the relationship between dissociation and anger in treatment-seeking veterans who presented for evaluation at the PTSD Clinic in the VA Ann Arbor Healthcare System during a four year period. A significant relationship was found between anger, dissociation, and PTSD severity. Anger and dissociation were also found to significantly predict PTSD severity. The implications of these results for clinical practice will be discussed.

Children's Global Assessment Scale (CGAS): Inter-Rater Reliability and Predictive Power

(Abstract #196386)

Poster # T-110 (Assess Dx, Child) **Exhibition Hall, 4th Floor**

Harish-Avidan, Shelly, MA[1]; Shafran, Naama, MA[1]; Rachamim, Lilach, MA[1]; Helpman, Liat, MA[1]; Weisman, Ynon, BA[1]; Gilboa-Schechtman, Eva, PhD[2]

[1]Psychology, Bar Ilan University, Ramat Gan, Israel
[2]Gonda Multidisciplinary Brain Research Center, Psychology, Bar Ilan University, Ramat Gan, Israel

The CGAS is a score given by a clinician to assess the patient's psychological functioning. It represents an integrated picture of the daily functioning in various settings (family, school etc.) together with the emotional distress of the child. The CGAS is a unique measure in that it is not limited to specific symptoms nor is it biased by the patient's self report. The inter-rater reliability of the CGAS has not been homogenous across studies, and results seem less than satisfying with children after trauma (Blake et al., 2007). In this study we analyzed the original scale to identify the main components of the score, and created anchor points to be used by raters. By applying this method we achieved high inter-rater reliability (r=0.94). forty-seven posttraumatic pediatric patients (25 boys, ages 7-18, mean = 12.6) began cognitive-behavioral treatment, out of which eleven patients did not complete full treatment course. Demographic variables, trauma characteristics and severity of PTSD at intake were not associated with drop-out. Higher CGAS score given at intake was significantly associated with treatment completion (t(46)=-2.8; P<0.05). In sum, a global score given by clinicians is an efficient measure that adds important prognostic data. Using simple guidelines in the evaluating process facilitates the achievement of high inter-rater reliability.

Stress Continuum Model Appplication to Military Leadership Education

(Abstract #195710)

Poster # T-111 (Mil Emer,Prev El) **Exhibition Hall, 4th Floor**

Nash, William, MD[1]; Grenier, Lt. Col Stephane, CCOM[2]; Bailey, Suzanne, MSW[3]; Thibeault, Rachel, PhD[4]

[1]U.S. Marine Corps, Quantico, Virginia, USA
[2]Canadian forces, Ottawa, Ontario, Armed Forces Canada, Canada
[3]Mental Health Training & Education, Canadian Forces Health Services Group HQ, Ottawa, Ontario, Canada
[4]Occupational Therapy Programme, University of Ottawa, Ottawa, Ontario, Canada

This Symposium will focus on the potential utilization of a non clinical "Stress Continuum Model" as the cornerstone of systemic leadership education interventions in the U.S. Marine Corps and Navy and a parallel program launched in the Canadian forces. While the Stress Continuum Model is anchored on sound clinical evidence, its simplicity offers military leaders a solid foundation upon which to determine how their subordinates are coping with operational stress and how they can best intervene. Discussants will also detail some of the key learning objectives and pedagogical approaches deemed necessary to teach leadership skills within the context of mental health disability management with a strategic goal of reducing stigma and removing barriers to care. The symposium will provide a clinical, academic and military leadership perspective of how best to educate military leaders capable of adapting their leadership to subordinates affected by mental health issues and operational stress and how the Canadian forces and the United States Marine Corps and Navy are working together to innovate in the area of mental health disability management and leadership training.

The U.S. Navy and Marine Corps Stress Continuum Model as a Tool to Promote Psychological Health in Warfighters and Veterans The community mental health approach to reducing long-term disability in service members, veterans, and their families due to operational stress requires an active partnership between warfighters, chaplains, and mental health professionals to promote prevention and early intervention. The conception of stress casualties in war as due largely to pre-existing personal weakness, prevalent since World War I, has made a community mental health approach to military stress all but impossible. After all, if combat stress reactions and sequelae such as posttraumatic stress disorder (PTSD) are merely manifestations of individual weakness, then what is there to prevent or intervene early to address, and why should suffering individuals admit to anyone they are afflicted? Through an active partnership between warfighters, chaplains, and mental health professionals, the U.S. Marine Corps and Navy have developed an alternative, destigmatizing conception of operational stress known as the "Stress Continuum Model," which is used to teach warfighters and families about four color-coded stress zones: green (ready and coping effectively), yellow (reacting but undamaged), orange (injured by stress but likely to recover), and red (ill or disordered). U.S. Marines and sailors are learning to use this shared language to promote effective prevention and early interventions.

Canadian forces Operational Stress & Mental Health Leadership education Soldiers have often failed to recognize symptoms of mental health problems and often avoid or delay accessing treatment services. More importantly perhaps is the way stigma plays a defining role in shaping behaviors of healthy soldiers towards those affected by Operational Stress Injuries (OSI) and how this often causes secondary wounding and worsens mental health outcomes. Military leaders need to view mental health problems including OSIs as being no less socially acceptable than physical ones. In order to shift attitudes, shape and model new behaviors and provide military leaders with the proper understanding of mental health issues and the appropriate frame of reference to adequately intervene, the Canadian forces has developed a systemic education campaign for every level of leader development. The campaign is designed to teach individual coping and resiliency skills and develop leadership skills partly based on the U.S. Marine Corps and Navy Stress Continuum Model. Using this model, leaders of the future will be able to make a distinction between pure behavioral and performance issues from ones caused by an under lying mental health condition, provide the appropriate level of support depending on the severity of the condition and most importantly learn how to adapt their leadership style to foster recovery rather than cause secondary wounding through punitive action.

Implementing a Seeking Safety Intervention in a Sample of People Living With HIV: A Pilot Study

(Abstract #200672)

Poster T-112 (Clin Res, Mil Emer) **Exhibition Hall, 4th Floor**

Boarts, Jessica, MA[1]; Armelie, Aaron, MA[1]; Delahanty, Douglas, PhD[1]

[1]Kent State University, Kent, Ohio, USA

People living with HIV (PLWH) often report disproportionately high rates of traumatic experiences, and consequently, increased PTSD symptoms. Additionally, PTSD and substance use/abuse are commonly comorbid, and have been associated with less than ideal medication adherence among PLWH. Seeking Safety (SS) therapy is designed to directly address PTSD and substance use comorbidity. The purpose of this ongoing pilot study is to investigate the efficacy of a group format SS therapy at treating PTSD and substance use. We hypothesized that participants receiving SS would exhibit lower PTSD symptoms and report less substance use as well as increased adherence to their HIV medications. PTSD symptoms, substance use, and adherence (both self-report and MEMS caps) are assessed at baseline (pre-intervention), post-intervention, and 3- and 6-months post-intervention. Findings will be discussed in terms of the benefits and shortcomings of a group format SS therapy in PWLH, and

possible efficacy of SS at decreasing PTSD and substance use, and increasing medication adherence.

Emotional and Psychosocial Functioning of Sri Lankan Youth Exposed to Traumatic and Daily Stressors

(Abstract #200545)

Poster T-113 (Child, Cul Div) **Exhibition Hall, 4th Floor**

Garcia, Janet, BA[1]; Fernando, Gaithri, PhD[1]; Chan, Samson, BA[1]; Miller, Ken, PhD[2]

[1]California State University, Los Angeles, California, USA

[2]Pomona College, Claremont, California, USA

The purpose of the current study was to examine the impact of traumatic and daily stressors on the emotional and psychosocial functioning of children in Sri Lanka. A sample of Tamil (174), Sinhalese (332), and Muslim (215) children (girls=391) between the ages of 12 and 19 (mean age =14.4, sd =1.9), completed a survey including demographic questions and items assessing the frequency of exposure to traumatic and daily stressors and emotional (posttraumatic stress, anxiety, and depression) and psychosocial functioning. Four hierarchical multiple regression analyses were conducted with demographic variables (age, gender, ethnicity, and religious affiliation) and total scores for the traumatic events scale and daily stressor scale as predictor variables. Results indicated that exposure to traumatic and daily stressors significantly predicted posttraumatic stress (R2 =.22, F (2,303) = 42.69, p<.001), anxiety (R2 =.140 F (2,308) = 24.87, p<.001), and depression (R2=.198 F (2,308) = 37.85, p<.001), with daily stressors adding significant predictive power to the models. Only traumatic exposure scores predicted psychosocial functioning scores (R2 =.15 F (2,308) = 26.96, p<.001). The results indicate that attention should be paid to both traumatic and daily stressors when considering the functioning of children living in developing countries.

Strategic Control of Emotional Numbing in PTSD

(Abstract #196527)

Poster # T-114 (Res Meth, Bio Med) **Exhibition Hall, 4th Floor**

Jaeger, Jeff A., BA[1]; Mueller, Tiffany M., BA[1]; Corning, Kendra B., BA[1]; Nikolayev, Irina, BA[1]; Zoellner, Lori, PhD[1]

[1]University of Washington, Seattle, Washington, USA

There is debate in the posttraumatic stress disorder (PTSD) field on whether emotional numbing (EN) is automatically (Foa et al., 1992; Litz, 1992) or strategically (Roemer et al., 2001) controlled. To date, no studies have experimentally manipulated experience of emotion while measuring subjective and objective indicators of emotional arousal. In this study, 66 men and women with PTSD, trauma-exposed no-PTSD, and healthy controls were asked to strategically manipulate their experience of EN via instructional set (EN, experience emotion, no instruction) and presented with affective images (positive, negative, neutral) examining self-reported emotion and psychophysiological responding (electrocardiogram, respiration, electromyogram). Consistent with a strategic theory of EN, for self-report all groups were able to modulate their emotions and reported less negative affect to EN than experience instructions; however, on objective indicators (specifically, electromyogram), only healthy controls, and not trauma-exposed individuals were able to strategically modulate their physiology responding. This discordance between response systems suggests that trauma-exposed individuals report strategic control over their subjective experience, but, for these individuals, physiological emotional arousal may be resistant to strategic influence and have more automatic properties.

Pharmacologic Alternatives to Antidepressants in Posttraumatic Stress Disorder: A Systematic Review

(Abstract #195781)

Poster # T-115 (Practice, Clin Res) **Exhibition Hall, 4th Floor**

Berger, William, MD[1]; Marques Portella, Carla, MD[2]; Mendlowicz, Mauro V., MD[3]; Kinrys, Gustavo, MD[4]; Marmar, Charles, MD[5]; Figueira, Ivan, MD[6]

[1]International Society for Traumatic Stress Studies, Rio de Janeiro, RJ, Brazil

[2]Federal University of Rio de Janeiro, Rio de Janeiro, Brazil

[3]Universidade Federal Fluminense, Niterói, RJ, Brazil

[4]Cambridge Health Alliance, Cambridge, Massachusetts, USA

[5]University of California San Francisco, San Francisco, California, USA

[6]Instituto de Psiquiatria (IPUB), Universidade Federal do Rio de Janeiro (UFRJ), Rio de Janeiro, Brazil

The objective of this study is systematic review the efficacy, level of evidence, and clinical relevance of several classes of psychopharmacological agents used for the treatment of PTSD available in the ISI Web of Science and PubMed databases. Articles with the main focus on the evaluation of antidepressant efficacy in PTSD or case reports with less than five patients were preliminarily excluded. Fifty-seven articles were selected, which included the following categories: antipsychotics, anticonvulsants, adrenergic-inhibiting agents, opioid antagonists, and other agents. None of the identified agents reached the level A of scientific evidence, 5 reached level B, 7 reached level C and 11 reached level D. The non-antidepressant agent with the highest level of scientific evidence for the treatment of PTSD was risperidone. Although, further controlled clinical trials and meta-analysis are necessary to assist and guide clinicians regarding the pharmacological alternatives to antidepressants in PTSD.

The Use of Solution-Focused Principles and Techniques in Treatment With Adult Survivors of Childhood Trauma

(Abstract #195824)

Poster # T-116 (Practice, Clin Res) **Exhibition Hall, 4th Floor**

Knight, Carolyn, PhD[1]

[1]School of Social Work, University of Maryland Baltimore County, Baltimore, Maryland, USA

Adults with histories of childhood trauma typically possess distortions in thinking about self and others and lack basic "self-capacities" that are associated with an individual's sense of competence like the ability to regulate affect, handle disagreement and rejection, and make decisions (Janoff-Bulman, 1992; McCann and Pearlman, 1990). A criticism of the trauma literature has been that it largely focuses on pathology (Bonanno, 2004). In fact, an impressive and growing body of research indicates that when individuals experience some benefit in response to their exposure to trauma, they adjust in healthier and more productive ways (Linley & Joseph, 2004). But, research also suggests that it is more difficult for survivors of childhood trauma to discern any adversarial growth, relative to individuals exposed to other types of trauma (Saakvitne, et. al., 1998).

Adopting a solution-focused perspective provides clinicians with a way to simultaneously promote posttraumatic growth and help clients develop self-capacities and alter their distorted views (Knight, 2009). In this workshop, the basic principles of solution-focused intervention will be identified: the client as an expert; searching for "what works" so that the client can "do more of it"; incremental change fosters continued growth; and the client's reality is socially and linguistically constructed (deShazer, 1990, 93-94). The defining techniques of solution-focused intervention also will be discussed, including asking about exceptions and pre- and between-session change, the miracle question, and coping questions. The relevance of these principles and techniques for practice with adult survivors of childhood trauma will be

examined, using case examples from a variety of practice settings and integrating current theory and research.

A Psychosocial Needs and Trauma Assessment of Tibetan Refugees Living in Nepal

(Abstract #195827)

Poster # T-117 (Civil Ref, Cul Div) **Exhibition Hall, 4th Floor**

Schwartz, Sam, MSW[1]; Tol, Wietse, MA[2]; Sharma, Bhogendra, MD, MSc[3]; de Jong, Joop, MD, PhD[4]
[1]Department of Veteran Affairs, Seattle, Washington, USA
[2]Department of Public Health and Research, VU University Medical Center, Amsterdam, Netherlands
[3]Centre for Victims of Torture, Nepal (CVICT), Kathmandu, Nepal
[4]Transcultural Psychiatry, VU University, Amsterdam, Netherlands

This study is a pilot investigation into the psychosocial needs of trauma-exposed Tibetan refugees living in Nepal. While other studies of Tibetan refugees have been done in India (Crescenzi et al, 2002, Terheggen et al, 2001, Holtz, 1998), very little is known about the psychosocial needs and stress reactions of Tibetan refugees in Nepal. This study of the Tibetan refugee community living in Nepal was conducted to explore their: 1. exposure to adverse and traumatic experiences, 2. psychosocial distress responses, 3. available resources, and 4. the possible need for additional psychosocial intervention. Twenty one Tibetan refugee participants were assessed using focus group discussions and in-depth interviews via snowball and convenience sampling. To establish a culturally valid interpretation of stressors and coping methods, the research was conducted with qualitative techniques. The extent to which traditional Tibetan coping mechanisms addresses the reactions of torture and trauma survivors is not well understood; as a result, a detailed look into the traditional Tibetan healing system as it operates in Nepal, was undertaken.

Posttraumatic Stress Disorder and Parenting: Examining a Mechanism of Trans-Generational Risk

(Abstract #196393)

Poster # T-118 (Ethics, Child) **Exhibition Hall, 4th Floor**

Ortigo, Dorthie, MA[1]; Guarnaccia, Clifford, PhD[2]; Ortigo, Kile M., MA[2]; Bradley, Rebekah, PhD[1]; Ressler, Kerry, MD[2]
[1]Emory University, Decatur, Georgia, USA
[2]Emory University, Atlanta, Georgia, USA

Trauma and PTSD are disproportionately common in low-SES urban women and children. Youth in this population are vulnerable for multiple factors that increase trauma and PTSD-related risk not only across the lifespan, but also potentially across generations. However, little research has examined mechanisms of transgenerational risk/resilience. We evaluate the relationship between maternal trauma exposure/PTSD and parenting style, parent-child interaction quality, and mother-reported child behavior. These data are part of an NIMH-funded study investigating environmental and genetic risk factors for PTSD in a sample of low-SES, primarily African American individuals seeking care in a public urban hospital. for women with trauma (84% lifetime; n=921), 44% report current clinically significant symptoms of PTSD. In a smaller sample (n=41), we compare mothers with no trauma, those with trauma but no PTSD, and those with trauma and PTSD using measures of parenting and child behavior. We find higher emotional distress and anxiety disorder symptoms in children of mothers with PTSD compared to children of mothers without PTSD, $p<.05$ and lower mother-reported relationship quality for mothers with PTSD as compared to those without PTSD, $p<.05$. We discuss theoretical and clinical implications within the framework of transgenerational mechanisms for PTSD risk and resilience.

Mapping Trauma: A Tool for Intervention and Advocacy

(Abstract #195843)

Poster # T-119 (Res Meth, Media) **Exhibition Hall, 4th Floor**

Putnam, Frank, MD[1]; Carrozza, Mark, MA[2]; Harris, William, PhD[3]
[1]Children's Hospital Medical Center, Cincinnati, Ohio, USA
[2]University of Cincinnati, Cincinnati, Ohio, USA
[3]Children's Research and Education Institute, Cambridge, Massachusetts, USA

A paradox of community violence is that while it is highly prevalent, it remains largely invisible to the public and policy makers. This invisibility is a function of many factors, but a critical one is the difficulty in communicating the scope of trauma. Tables, charts, and graphs of complex data are not readily understood by non-scientists. Animated maps are now used by the media to depict complicated relationships. As a result, policy makers are better able to comprehend research data displayed on maps, especially when it relates to their community. The Child Mapping Project creates interactive computerized maps with user selectable overlays of research data that allow viewers to `connect the dots' for themselves. Examples illustrate ways in which the scope of community trauma, its social and economic impacts, and the effects of interventions can be compellingly demonstrated. Empirical examples will demonstrate: the high co-occurrence rates of infant mortality, child abuse, and domestic violence in Cincinnati; prediction of community violence 'hot spots' from US Census data: and the economic impact of public policies.

Are Patients Who Drop Out of a Longitudinal Study at High Risk for Posttraumatic Stress Disorder?

(Abstract #195849)

Poster # T-120 (Res Meth, Assess Dx) **Exhibition Hall, 4th Floor**

Nishi, Daisuke, MD[1]; Matsuoka, Yutaka, PhD[2]; Nakajima, Satomi, PhD[2]; Noguchi, Hiroko, MA[3]; Kim, Yoshiharu, PhD[2]; Schnyder, Ulrich, MD4
[1]National Disaster Medical Center, Tachikawa, Tokyo, Japan
[2]National Center of Neurology and Psychiatry, Kodaira, Tokyo, Japan
[3]Musashino University, Nishitokyo, Tokyo, Japan
[4]Zurich University Hospital, Zurich, Switzerland

In longitudinal studies of traumatic stress, it is particularly important to examine the data for any differences between those who drop out and those who continue to participate, because reluctance to participate might reflect symptoms of avoidance seen in posttraumatic stress disorder (PTSD). Over a 25-month period, 188 consecutive patients with motor vehicle accident (MVA)-related injuries admitted emergently were enrolled and followed for 4-6 weeks. Baseline characteristics were compared between subjects who did and did not participate in the follow-up study. At 4-6 weeks, 66 (35.1%) of the participants dropped out. Logistic regression analysis revealed that male gender, unconsciousness during MVA, low cooperativeness assessed by the Temperament and Character Inventory, and less severe injuries were significant predictors of dropout. The literature says that male gender and unconsciousness just after MVA might be protective factors against MVA-related PTSD, whereas low cooperativeness, a risk factor for general mental problems. To summarize, it is suspected that those who drop out from the follow up are unlikely to have MVA-related PTSD, but might have mental problems independent of injury.

Self-Blame Attributions Predict Level of Posttraumatic Distress

(Abstract #195850)

Poster # T-121 (Clin Res, Assess Dx) **Exhibition Hall, 4th Floor**

Joseph, Jeremy, AB[1]; Gray, Matt, PhD[1]
[1]University of Wyoming, Laramie, Wyoming, USA

Blaming oneself for a traumatic event has been linked to symptom severity and depression. On the other hand, perceptions of control over self following a trauma have been associated with resilience and posttraumatic growth. In an effort to explain this apparent contradiction, Janoff-Bulman proposed making the distinction between behavioral and characterological self-blame.
We conducted a secondary analysis of participants who blamed themselves for their traumatic experiences. Specifically, we examined the degree to which other attributional dimensions (global-specific and stable-unstable) are associated with distress among self-blamers. If Janoff-Bulman's theory is correct, self-blamers citing specific and unstable causes (e.g. "I shouldn't have walked down that street alone") for their traumatic events should evidence better posttraumatic adjustment compared to self-blamers citing stable and global factors (e.g. "I am too trusting"). Preliminary analyses show that the adaptiveness of self-blame following a traumatic event is different depending on the specificity of attributions offered for the traumatic event. Consistent with Janoff-Bulman's theory, it appears that self-blame, when coupled with specific and unstable attributions, actually enhances self-efficacy.

Posttraumatic Stress and Depression Severity as Correlates of Health Problems Among Veterans (Abstract #195852)

Poster # T-122 (Mil Emer, Bio Med) **Exhibition Hall, 4th Floor**

Pekevski, Jordan, MA[1]; Richardson, Don, MD[2]; Elhai, Jon, PhD[1]
[1]Disaster Mental Health Institute, University of South Dakota, Vermillion, South Dakota, USA
[2]University of Western Ontario, London, Ontario, Canada

Studies have reported a relationship between posttraumatic stress disorder (PTSD) and major depressive disorder (MDD) on the one hand, and physical health problems on the other. Military veterans are particularly vulnerable to mental disorders such as PTSD and MDD, which may in turn leave them vulnerable to physical health problems. The purpose of this study was to examine the relationship between both PTSD and MDD, and four health conditions (gastrointestinal disorders, joint/rheumatological problems, headaches, and cardiovascular problems), and whether relationships remained once demographic factors were controlled. Participants included 707 Canadian Peacekeeping Veterans who had been deployed overseas. The PTSD Checklist-Military Version was used to measure PTSD symptoms, and the Center for Epidemiological Studies-Depression Scale was used to measure MDD symptoms. Both PTSD and MDD were significantly related to gastrointestinal disorders, joint/rheumatological problems, and headaches. Cardiovascular problems were not related to either PTSD or MDD. The relationship between MDD and joint/rheumatological problems was not significant after demographic factors were controlled. Overall, the results support the theory of a relationship between mental health and physical health.

Poster # T-123 (withdrawn)

N400 as a Measure of Semantic Expectancy in Trauma Survivors

(Abstract #195862)

Poster # T-124 (Bio Med, Mil Emer) **Exhibition Hall, 4th Floor**

Kimble, Matthew, PhD[1]; Batterink, Laura, B.A.[2]; Marks, Libby, BA Candidate[3]; Bababekov, Yan, BA Candidate[4]
[1]Middlebury College, Middlebury, Vermont, USA
[2]University of Oregon, Eugene, Oregon, USA
[3]Middelbury College, Middlebury, Vermont, USA
[4]Middlebury College, Middlebury, Vermont, USA

The N400 is an event related potential that is sensitive to semantic expectancy. Sentences with unexpected endings (i.e., "The coffee was purple") produce large N400s to final words. We tested whether veterans with PTSD (compared to veterans without PTSD and other trauma survivors) might show semantic expectancies for trauma relevant (combat) final words in sentences. Eighteen participants have completed the protocol. Twenty-one sentence stems were presented three times each and ended with either an expected, unexpected, or trauma relevant final word, i.e, the sentence stem "The night sky was filled with _____" was presented three times and ended with either the final word "stars" (the expected condition), "computers" (unexpected condition), or "tracers" (trauma-relevant condition). There was a significant interaction between sentence type and group. Regardless of military status, participants in the PTSD group exhibited significantly smaller N400s for both the unexpected and trauma-relevant sentence endings. This finding suggests an inability to generate semantic expectancies that is consistent with working memory difficulties and not a specific, trauma relevant information bias.

Longitudinal Analysis of Children's Social Support Seeking Coping Behavior After Residential Fire

(Abstract #196447)

Poster # T-125 (Child, Disaster) **Exhibition Hall, 4th Floor**

Hadder, James, BS[1]; Immel, Christopher, BS[1]; Knepp, Michael, MS[1]; Jones, Russell, PhD[1]; Ollendick, Thomas, PhD[1]
[1]Virginia Polytechnic Institute and State University, Blacksburg, Virginia, USA

Results of a longitudinal study examining change in children's coping strategies following residential fire are described. Strategies examined were: active, distraction, avoidant, and social support seeking. Additionally, we examined the degree to which the use of social support seeking coping longitudinally could be predicted by the use of one or more of the remaining three strategies at times 1 and 2. At times 1 through 3, the use of social support seeking coping was significantly correlated with the three other coping methods measured by the scale longitudinally. Results indicate 35.5% of the variance in the extent to which children employed social support seeking coping at time three could be accounted for by examining how often these children implemented the other three methods at times 1 and 2. Additionally, 26.7% of the variance could be explained by examining the degree to which the other three methods were employed at time 1. Finally, 62.4% of the variance in social support seeking coping was explained by examining the extent to which the other three methods were employed at all times. We conclude that children involved in residential fire engage in consistent styles of coping across time. Additionally, the mechanisms involved in each of the four strategies may be largely similar.

Transference and Countertransference Issues in Working With Victims of Violent Crime and Other Traumatic Incidents of Adulthood

(Abstract #195867)

Poster # T-126 (Assess Dx, Practice) **Exhibition Hall, 4th Floor**

Shubs, Carl H., PhD[1]

[1]*Private Practice, Beverly Hills, California, USA*

Using victims of violent crime as a reference point regarding the treatment of traumatic incidents of adulthood, transference and countertransference are examined in working with traumatic incidents of adulthood. Violence-based parataxic distortions (V-PDs) are distinguished from transference reactions, with recommendations for an integrative listening perspective. Specific V-PDs are identified. Countertransference is examined regarding Freud's impediment theory, implications concerning empathic strain, and vicarious traumatization. A new communicative countertransference perspective is offered.

Psychological First Aid

(Abstract #195875)

Poster # T-127 (Disaster,Prev EI) **Exhibition Hall, 4th Floor**

Technical Level: Introductory

Watson, Patricia, PhD[1]; **Brymer, Melissa, PhD**[2]; **Ruzek, Josef, PhD**[3]; **Layne, Christopher, PhD**[2]; **Vernberg, Eric, PhD**[4]

[1]*Dartmouth College, White River Junction, Vermont, USA*
[2]*National Child Traumatic Stress Network, Los Angeles, California, USA*
[3]*National Center for PTSD, Palo Alto, California, USA*
[4]*University of Kansas, Lawrence, Kansas, USA*

This poster will offer information on the Psychological First Aid Field Guide, developed by the National Child Traumatic Stress Network and the National Center for PTSD. This intervention was developed for use in the acute aftermath of disasters and mass violence. The poster will include information on a series of modules that are meant to be used in a flexible, pragmatic manner, based on based on information gathered about immediate needs and priorities. The interventions are appropriate for both children and adults, and include such actions making contact, establishing safety and comfort, stabilizing emotional states, information gathering, offering practical assistance, enhancing connection with social supports, information on coping, and linkage with collaborative services. Also discussed will be variations of the protocol with different audiences and in different settings (i.e., shelters, schools, workplace, etc).

Holographic Reprocessing: Techniques and Empirical Findings to Treat Sexual Trauma and Abuse

(Abstract #195878)

Poster # T-128 (Practice, Clin Res) **Exhibition Hall, 4th Floor**

Katz, Lori, PhD[1]; **Snetter, Miatta, PsyD**[1]; **Cojucar, Geta, MS**[1]

[1]*Mental Health, VA Long Beach Healthcare System, Long Beach, California, USA*

Holographic Reprocessing (HR) (Katz, 2001, 2005) is an integrative treatment for single episode and complex sexual trauma, or childhood maltreatment such as neglect. Results of two clinical outcome studies and three mechanism studies will be reviewed. Emphasis will be on theory and practical techniques of HR.

HR addresses the impact of trauma on self-perceptions and interpersonal relationships. By reviewing life patterns, clients identify core violations, beliefs, and strategies they use to compensate for or avoid negative affect. HR utilizes a variety of therapeutic techniques including: skill-enhancement, novel cognitive reframing techniques, holistic reappraisal, and imaginal rescripting. During the "reprocessing phase" of treatment, clients revisit a formative event from the objective vantage point where clients remain anchored as their current aged-self viewing the scene as if watching it from afar. This creates emotional distance, decreases distress, and facilitates a holistic reappraisal of the event. Clients are able to release negative affect, self-blame, and negative thoughts about the self. Using imaginal rescripting, clients enter a scene as their current aged-self to deliver communications and offer comfort and support to the younger self who experienced the sexual trauma or abuse. Case examples and practical tools will be presented throughout this multi-media workshop.

Measuring Posttraumatic Stress in Children: The Children's Responses to Trauma Inventory (CRTI)

(Abstract #195880)

Poster # T-129 (Child, Assess Dx) **Exhibition Hall, 4th Floor**

Alisic, Eva, MA, MSc[1]; **Van Der Schoot, Tom A. W., PhD**[1]; **Kleber, Rolf J., PhD**[2]

[1]*Psychotrauma Center for Children and Youth, University Medical Center Utrecht, Utrecht, Netherlands*
[2]*Department of Clinical and Health Psychology, Utrecht University, Utrecht, Netherlands*

The Children's Responses to Trauma Inventory (CRTI; Alisic, Eland, & Kleber, 2006) is a self-report measure for posttraumatic stress. Its 34 items incorporate the *DSM-IV* criteria for PTSD as well as child-specific stress reactions, such as separation anxiety and regressive behavior, in line with the debate on the validity of the *DSM-IV* criteria for PTSD in children (see e.g. Scheeringa et al., 2006). This approach is exceptional while most child measures focus exclusively on the *DSM-IV* criteria for PTSD or, on the opposite, include them only partially in the context of a broader approach. We validated the CRTI in a sample of 246 traumatized primary school children in the normal Dutch population (age range 7.4-13.7, mean age 10.5, 52,4% boys). We found good to excellent reliability for the total scale and the four subscales. Convergent validity was established against the Children's Revised Impact of Event Scale-13 (CRIES-13; Children and War Foundation, 1998) and against the subscale for Psychological Well-being of the KIDSCREEN-27 (Ravens-Sieberer et al., 2001). The measure itself (English version), its psychometric characteristics, and preliminary normative data will be presented.

PTSD, Nicotine Withdrawal, and Anxious and Fearful Reactivity to Bodily Arousal

(Abstract #195881)

Poster # T-130 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Smith, Rose, MA[1]; **Vujanovic, Anka, MA**[2]; **Gibson, Laura, PhD**[3]; **Zvolensky, Michael, PhD**[2]; **Feldner, Matthew, PhD**[1]

[1]*Department of Psychology, University of Arkansas, Fayetteville, Arkansas, USA*
[2]*Psychology, University of Vermont, Burlington, VT, USA*
[3]*University of Vermont, Burlington, Vermont, USA*

Posttraumatic stress disorder (PTSD) is associated with high rates of smoking and fear of bodily perturbation. The current study examined the role of nicotine withdrawal in the association between PTSD and responding to bodily arousal among 52 participants (27 women; M age = 30.50 years). Compared to participants without current axis I psychopathology, persons with current PTSD responded to a three-minute voluntary hyperventilation procedure with greater increases in anxiety and more intense cognitive and physical panic symptoms, despite no group differences in physiological arousal. Nicotine withdrawal demonstrated significant mediational effects in the relations between diagnostic group and panic symptoms elicited by the hyperventilation procedure. Findings suggest nicotine withdrawal is an important factor to consider in terms of better understanding the nature of fear responding to bodily sensations among persons with PTSD.

The Role of Nicotine Dependence in the Relationship Between PTSD and Panic in a National Sample

(Abstract #195882)

Poster # T-131 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Bown, Stevie, BA[1]; Grooms, Amy, BA[1]; Smith, Rose C., MA[1]; Babson, Kimberly, MA[1]; Feldner, Matthew, PhD[1]

[1]University of Arkansas, Fayetteville, Arkansas, USA

Posttraumatic stress disorder (PTSD) frequently co-occurs with panic spectrum problems. Relatively little empirical work has tested possible mechanisms accounting for this association. People with PTSD often are heavy smokers and research suggests heavy smoking may lead to panic problems. The current study tested the hypotheses that nicotine dependence mediates the relations between PTSD and both panic attack histories and panic disorder within a nationally representative sample of 5692 (3311 females; M Age = 43.33, SD = 16.55) adults from the National Comorbidity Survey - Replication. Results were consistent with hypotheses. These findings support theory suggesting smoking subsequent to the development of PTSD may lead to the development of panic problems.

The Effects of Quantitative and Qualitative Trauma-Focused Research on Pregnant Female Participants

(Abstract #195884)

Poster # T-132 (Res Meth, Ethics) **Exhibition Hall, 4th Floor**

Schwerdtfeger, Kami, PhD[1]

[1]Oklahoma State University, Stillwater, Oklahoma, USA

The current study investigated how pregnant female participants respond to quantitative and qualitative trauma-focused research. The study is part of a larger, two-phase mixed-methods study exploring trauma and pregnancy. Phase I of the study involved a large-scale, self-completion survey of 109 pregnant females. The aim of Phase I was to collect quantitative data concerning the experience and impact of trauma during pregnancy. Phase II of the study involved a sub-sample of pregnant females (n = 10) selected on specified trauma criteria and drawn from the first phase of the study. Phase II utilized a semi-structured interview to explore possible connection between pregnant females' past sexual trauma experiences and subsequent experiences of pregnancy. Upon completion of each phase of the study, participants were asked to complete a measure assessing their reaction to participation in trauma-focused research. Overall, the results of this study suggest that both quantitative and qualitative trauma-focused research methods are well tolerated by pregnant women. Recommendations for conducting ethical research with pregnant women and other potentially high-risk populations will be provided.

A Closer Look at Long-Term Effects of Childhood Trauma: A Case Example of a Child in Foster Care

(Abstract #195888)

Poster # T-133 (Child, Practice) **Exhibition Hall, 4th Floor**

Chavez, Veronica, PsyD[1]; Garcia, Ediza, PsyD[2]; Orellana, Blanca, PhD[3]; Park, Susan, PhD[4]

[1]Project Heal Trauma Program/Foster Care HUB, Children's Hospital of Los Angeles, Los Angeles, California, USA
[2]Project Heal Trauma Program/Foster Care HUB, Childrens Hospital Los Angeles, Los Angeles, California, USA
[3]Ptoject Heal Trauma Program, Children's Hospital of Los Angeles, Los Angeles, California, USA
[4]Child and Family, Childrens Hospital Los Angeles, Los Angeles, California, USA

Statistics show that a little over half a million children in the United States are currently living in foster homes due to sexual abuse, physical abuse, general neglect, and/or witnessing domestic violence. Although the effects of trauma on a child have been investigated for many years, there is limited research on the unique after effects associated with trauma, development, and foster care. The trauma experienced in the biological home compounded with removal from that home may result in significant distress for a child, especially during critical years of development. This distress, along with, numerous foster care placements often result in life long pervasive challenges that can be ostracizing from society. Subsequently, research indicates that children in foster care have a disproportionately high prevalence of mental health disorders, which often go untreated or misdiagnosed. Studies have found that foster children develop impairments among social, academic, psychological, neurological, and behavioral domains.

Therefore, children in foster care are at higher risk for difficulties across various domains of functioning. This workshop will provide a context for this social issue by discussing the aftermath of trauma exposure and the challenges of working with a child in foster care through the examination of a case example.

The Consolidation of Associated Memory With Fear Salience is Manipulated by Sustained Wakefulness

(Abstract #195893)

Poster # T-134 (Bio Med, Clin Res) **Exhibition Hall, 4th Floor**

Kuriyama, Kenichi, MD, PhD[1]; Soshi, Takahiro, PhD[1]; Kim, Yoshiharu, MD, PhD[1]

[1]Adult Mental Health, National Institute of Mental Health, NCNP Japan, Kodaira, Tokyo, Japan

Fear memory consolidation is suspected to be involved in a core mechanism of PTSD. Several studies still demonstrated that fear memory itself is more enhanced in consolidation processes. Furthermore sleep deprivation manipulates it into strengthening. In PTSD patients, recall of some incidental information associated with the traumatic memory often trigger reexperiencing of the traumatic event. So we examined the behavior of associated memory with fear stimuli consolidation and the impact of sleep loss on associated memory consolidation simultaneously. We found a contradictive behavior of associated memory with fear salience in sleep deprived group. The sleep deprived group showed low recall rate on paired association memory with fear salience than that with low emotional valence. The right prefrontal dysfunction in sleep deprived group on recall phase was also revealed by fNIRS. These findings suggest that a gap in consolidated intensity between associated memory with fear salience and fear memory itself under sleep deprived condition is based on the right prefrontal dysfunction, that is concerned with PTSD pathology.

The Novelty P300 as an Index of Symptom Severity in Trauma Survivors

(Abstract #195899)

Poster # T-135 (Bio Med, Assess Dx) **Exhibition Hall, 4th Floor**

Kimble, Matthew, PhD[1]; Bowman, Molly, BA[2]; Bababekov, Yanik, BA Candidate[2]; Marks, Libby, BA Candidate[3]

[1]Psychology, Middlebury College, Middlebury, Vermont, USA
[2]Middlebury College, Middlebury, Vermont, USA
[3]Middelbury College, Middlebury, Vermont, USA

Introduction: The "novelty P300" is a large positive event related potential (ERP)that occurs to the presentation of a surprising or novel stimulus. It has been suggested that the novelty P300 indexes automatic attention or novelty detection and may be sensitive to hypervigilance in PTSD samples (Kimble et al 2000). Methods: Eighteen mixed trauma participants participated in a diagnostic evaluation followed by a novelty P300 protocol in which novel sounds were embedded among a series of tones. The PTSD Symptom Scale, Beck Depression Inventory, and the Dissociative Experiences Scale were placed into a multiple regression in order to predict novelty P300 amplitude.

Results: Only depression scores predicted unique variance in novelty P300 amplitude. Psychometric scores did not predict amplitude to target tones or latency to any stimuli. Discussion: This is consistent with other research indicating that 1) the novelty P300 as opposed to other components is consistently sensitive to psychopathology, and 2) syndromes other than PTSD are more reliable in predicting electrophysiological performance in traumatized samples.

The Art of Psycho-Traumatology (Introducing the Healing Environment)

(Abstract #195908)

Poster # T-136 (Disaster,Prev EI) **Exhibition Hall, 4th Floor**

Mohamed, Omar, MD[1]

[1]Psychiatry, The University of Tennessee Health Sciences Center, Memphis, Tennessee, USA

This poster is intended to introduce the topic of the healing environment as an essential part of coping with mental health effects of trauma and disasters.

The poster first divides disasters into natural and man-made and then discusses the effects of disasters on individuals and societies.

The mental health consequences of disasters, the role of psychiatry before, during and after disasters, and the importance of psychological first aid are also briefly included.

Finally the art of psycho-traumatology, namely the idea of the healing environment (turning a disaster zone into a healing space) is introduced in detail towards the end of this poster.

Tonic Immobility Associated With Cortisol Response in Brazilian Peacekeepers After an Acute Stress

(Abstract #196450)

Poster # T-137 (Bio Med, Mil Emer) **Exhibition Hall, 4th Floor**

Mendonça-de-Souza, Ana Carolina, MSc[1]; Souza, Wanderson, MSc[2]; Fischer, Nastassja, BCH[1]; Barros, Eduardo, BCH[1]; Volchan, Eliane, MD[3]; Figueira, Ivan, MD[1]

[1]Federal University of Rio de- Janeiro, Rio de Janeiro, Brazil
[2]ENSP, Rio de Janeiro, Brazil
[3]Institute of Biophysics Carlos Chagas Filho, Universidade Federal do Rio de Janeiro, Rio de Janeiro, Brazil

Exposure to combat-related stressful events can result in long-term psychological adjustment problems, such as posttraumatic stress disorder (PTSD). The present study aims to study the impact of a chronic stress on HPA axis reactivity in Brazilian peacekeepers. We investigated the impact of deployment stressors in cortisol response to a subsequent acute stress. We measured cortisol response to an acute stress in 54 soldiers that spend 6 months in a peacekeeping mission on Haiti. We collected 5 saliva samples at -10, -5, +15, +25, +35 minutes relative to the beginning of the task. Cortisol concentrations were measured by Enzyme Immunoassays and psychometric scales were used to measure individual variability. Analysis of cortisol response showed a significant increase in salivary cortisol +15 and +25 minutes after beginning of the task. Moreover, individuals with higher Tonic Immobility (TI) scores during the task showed greater cortisol responses. Our results suggest that individuals with high TI are more responsive to stressful situations. Tonic immobility is a reflexive and involuntary defensive response that has a positive correlation with PTSD symptoms. This relationship between TI and poor prognosis to PTSD suggests that TI could constitute a vulnerability factor for the development of psychopathologies related to stress in these individuals.

Witnessing the Fall: The Crisis of the Permeable Self

(Abstract #195911)

Poster # T-138 (Cul Div, Ethics) **Exhibition Hall, 4th Floor**

Muller, Christine, MA[1]

[1]American Studies, University of Maryland College Park, College Park, Maryland, USA

On Sept. 11, 2001, world news audiences witnessed about one in every six of the dead from the World Trade Center's North Tower jumping to their deaths. Analyses of popular culture discourse, such as Tom Junod's Esquire article "The Falling Man" and PBS's Frontline documentary "Faith and Doubt at Ground Zero," indicate that such witnessing prompts both identification with and resistance to the falling figures. While recognizing these figures as human beings like ourselves, we also recognize their dilemma as something we too would never want to face. Witnessing in this way the precariousness of others and so, conceivably, that of our own agency and bodily integrity, foregrounds our sense of self by violating it, by showing what we cannot completely control: our lives and the circumstances that affect them. This breach generates a sense of our selves as permeable. In effect, the permeable self is the experience of tension between identification with and resistance to those who are vulnerable because their vulnerability prompts consideration of our own contingent power and fortune. Such tension points to the ethically divergent responses vulnerability evokes, granting grounds for both rejection of and compassion for the vulnerable Other, who is also yourself.

Participant Alert: This paper dwells on self-reflexivity among witnesses to trauma.

The Ineffable Knowledge of Horror

(Abstract #195912)

Poster # T-139 (Cul Div, Ethics) **Exhibition Hall, 4th Floor**

Muller, Christine, MA[1]

[1]American Studies, University of Maryland College Park, College Park, Maryland, USA

"They were howling because they knew, but their vocal cords had snapped in their throats." Charlotte Delbo refers to women in a truck filled with corpses at Auschwitz, women who know they will be burned alive with the dead around them. Her words conjure a visceral understanding of horror as scorching the mind and breaking the body. With their unheard howls, these women bewail knowledge that exceeds any possibility of mental or physical accommodation. This traumatic rupture informs Delbo's repeated invocation, "O you who know," a textual heuristic for Auschwitz and After that compels readers to question whether they should recognize themselves in the "you" and therefore reconsider what they know and, accordingly, what they can know when engaging

with her text. This reading ethic responds to the text's presentation of horror as destroying certain kinds of knowledge and creating others, integrally responding to trauma's existentially destabilizing effects. Survivors of and witnesses to the Holocaust and other traumatic, perpetrated events contend with the shattering of the most fundamental premises of their relationships with themselves and others. Who will do what kinds of harm, and how can we make sense of it?

Participant Alert: This paper dwells on self-reflexivity among witnesses to trauma.

Managing Fear: The Essential Role of Leaders and First Responders in Disaster Response

(Abstract #195916)

Poster # T-140 (Disaster, Mil Emer) **Exhibition Hall, 4th Floor**

Berkowitz, Steven, MD[1]; Marans, Steven, PhD[2]; Gist, Richard, PhD[3]
[1]Yale University, New Haven, Connecticut, USA
[2]Child Study Center, Yale University, New Haven, Connecticut, USA
[3]University of Missouri-Kansas City, Kansas City, Missouri, USA

This poster will present a curriculum for government and first responders that increase their understanding of the emotional and behavioral reactions of people impacted by disaster. The curriculum's premise is that by understanding the psychological impact of disaster, they will respond more respond effectively. Also, it demonstrates the methods by which they can use their established authority to provide effective psychologically informed interventions in the course of their immediate response activities. This curriculum is based on years of experience in providing first responder-mental health collaborations for a range of PTE"S. All catastrophic events have immediate and long lasting psychological impact. There has been the general acceptance of the 3 general categories of population based response. Category 3 are those who recover with minimal support, Category 2 have more difficulties but eventually recover with little intervention and Category 1 develop clear posttraumatic problems and require treatment. A primary goal of early psychological interventions is to increase the numbers that remain in Category 3. These trauma-informed interventions may be best performed by those responding in immediate aftermath-governmental leaders and first responders. When appropriately trained and supported they are best placed to be effective community wide psychological interveners.

Mediators of the Relationship Between Pre-Trauma Self-Esteem and Post-Trauma PTSD Symptoms

(Abstract #195918)

Poster # T-141 (Clin Res,Prev EI) **Exhibition Hall, 4th Floor**

Hirai, Reiko, MA[1]; Frazier, Patricia, PhD[2]; Sanders, Samantha, BA[1]; Perera, Sulani, BA[1]; Gavian, Margaret, MA[2]
[1]Psychology, University of Minnesota, Minneapolis, Minnesota, USA
[2]University of Minnesota, Minneapolis, Minnesota, USA

Purpose: In our prospective study of trauma (Gavian et al., 2008), pre-trauma self-esteem was one of the strongest predictors of post-trauma PTSD symptoms, with higher self-esteem predicting fewer symptoms. The purpose of this study is to identify factors that might explain this relation.

Methods: Our sample consisted of students (N = 122) who reported a *DSM-IV* traumatic event in the 2 months between the Time 1 and Time 2 assessments. Nine potential mediators of the relation between self-esteem and PTSD symptoms were explored: helpful and unhelpful social support, four types of coping (understanding emotions, positive reappraisal, denial, acceptance), and three aspects of control over the trauma (past, present, future). All variables were assessed using standard measures.

Findings: Of the nine potential mediators, four (unhelpful social support, denial, past control, present control) were significantly associated with both self-esteem and PTSD symptoms. In regression analyses, unhelpful social support, denial, and present control partially mediated the relationship between self-esteem and PTSD symptoms although self-esteem remained significant in each equation. When all four mediators were entered, self-esteem no longer predicted PTSD symptoms.

Conclusions: Our findings help to explain the mechanisms by which self-esteem is a pre-trauma protective factor.

Dreaming in PTSD: New Insight From Longitudinal Studies

(Abstract #195921)

Poster # T-142 (Clin Res, Assess Dx) **Exhibition Hall, 4th Floor**

Wittmann, Lutz, PhD[1]; Kobayashi, Ihori, MS[2]; Jenifer, Ericka, MS[3]; Kramer, Milton, MD[4]; Jenni, Oskar, MA[5]; Landolt, Markus, PhD[5]; Fallon, Jr, William F., MD[6]; Martin, Berni, MSN, RN[6]; Humphrys, Kimberly, MSN, RN[6]; Martinez, Julia, BA[7]; Delahanty, Doug, PhD[2]; Mellman, Thomas, MD[3]
[1]Psychiatric Department, University Hospital Zurich, Zurich, Switzerland
[2]Kent State University, Kent, Ohio, USA
[3]Department of Psychiatry & Biological Sciences, Howard University, Washington, District of Columbia, USA
[4]Department of Psychiatry, University of Illinois at Chicago, Chicago, Illinois, USA
[5]Kinderspital Zurich, Zurich, Switzerland
[6]Division of Trauma, Summa Health System, Akron, Ohio, USA
[7]University of Missouri, Columbia, Missouri, USA

Posttraumatic dreams can further our understanding of PTSD and of dream functions. However, previous research paid insufficient attention to crucial methodological factors such as longitudinal designs. This symposium present findings of three independent research groups based on longitudinal data illuminating the interaction of day and night time posttraumatic stress.

Nightmares Soon After a Serious Injury Predict Subsequent PTSD Symptoms

Cross-sectional studies have shown associations between chronic trauma-related nightmares and PTSD symptoms. The present study prospectively examined the effects of nightmares 3 weeks after a serious injury on subsequent PTSD symptoms. 29 injury patients completed a 1-week sleep diary during the third week post-injury. The Acute Stress Disorder Interview (ASDI) and the Clinician Administered PTSD Scale (CAPS) were administered 3 and 7-weeks post-injury, respectively. Total CAPS scores were computed excluding the two sleep-related items. Only 12 participants reported having at least one nightmare in their sleep dairies; therefore, the nightmare variable was coded dichotomously, presence (1) or absence (0). Participants reporting nightmares scored significantly higher on the CAPS (43.8 vs. 15.1, t=3.40, p=.002) than the no-nightmare participants. A hierarchical linear regression was conducted predicting CAPS scores from nightmares. After controlling for demographics and ASDI scores, nightmares significantly predicted the CAPS scores (B=16.5, R2=.08, p=.029). Among participants reporting nightmares, the correlation between levels of similarity of nightmares to their trauma and the CAPS scores was medium, r=.36, but was not significant, p=.27. Results suggest that presence of nightmares soon after a traumatic event may indicate the greater risk for subsequent PTSD symptoms.

Dream Trajectories in the Acute Aftermath of Trauma

There is evidence that dreaming contributes to emotional memory processing. We hypothesized that sequential dreams following injury would become less similar to trauma and that this effect would be mitigated with PTSD. Twenty six participants of a larger study of PTSD following traumatic injury provided at least 2 dream report diaries within a month of traumatic injury. Self ratings of the dream's similarity to the trauma were reduced from the first to the second dream, while ratings for how "disturbing" the dream

was were similar. The degree of similarity for the second, but not the first, dream was significantly correlated with PTSD severity. These findings support an emotional processing function for dreaming that is compromised with early PTSD symptoms.

Dreaming and Posttraumatic Stress in Children After Traffic Accidents

To better understand the relation between different types of nightmares and psychopathology after trauma, a prospective study of children after traffic accidents was performed. 97 children were assessed with regard to PTSD, other psychiatric symptoms, and dreams and nightmares, 7-10 days, 2, and 6 months post accident. Nightmares were classified according to the dimensions of similarity to the trauma and repetitive appearance, and related to psychopathological sequelae. Mean age was 10 years (range 7-16), 1/3 were females. Rates of ASD/PTSD were around 20%. Controlling for pre-accident dream and nightmare recall frequency (2/3 and 1/2 of subjects, respectively), the presentation of results will focus on nightmare frequencies at the three time points (20-50%) and the association of different nightmare types with psychopathological symptoms. Studying posttraumatic nightmares is a valuable tool to further our understanding of PTSD and the function(s) of dreaming.

Clarifying the Comorbidity Conundrum: Exploring the Relationship Between PTSD and Depression

(Abstract #196486)

Poster # T-143 (Assess Dx, Res Meth) **Exhibition Hall, 4th Floor**

Duax, Jeanne, MA[1]; Zoellner, Lori, PhD[2]; Feeny, Norah, PhD[3]
[1]Case Western Reserve University, Cleveland Heights, Ohio, USA
[2]University of Washington, Seattle, Washington, USA
[3]Case Western Reserve University, Cleveland, Ohio, USA

Posttraumatic stress disorder (PTSD) is a debilitating and chronic mental illness that affects approximately 7% of individuals over their lifetimes (Kessler, Berglund, et al., 2005). PTSD is also a highly comorbid condition, particularly with regard to major depression (Kessler, Chiu, et al., 2005). Comorbid cases of PTSD and depression have been associated with deleterious correlates including heightened risk for attempted suicide (Oquendo et al., 2005), a more chronic course of psychopathology and impairment (Breslau et al., 1991), and attenuated treatment response (Green et al., 2006). The goals of this presentation are to (1) review the epidemiological data of comorbid PTSD and depression published since 1980, (2) conduct and review the results of a PsycINFO and MEDLINE literature search of articles published between 1987 and 2007 that present data on comorbid PTSD and depression, and (3) examine comorbid PTSD and depression in terms of Clark & Watson's (1991) tripartite model of anxiety and depression and cognitive theories. Based on this literature review, we suggest that comorbid PTSD and depression represents a severe form of PTSD rather than separate, co-occurring conditions. Future directions include considering ways to revise existent treatment packages to better serve individuals with co-occurring PTSD and depression.

Psychological IPV Predicts Women's Mental Health and Children's Behavior Problems

(Abstract #196492)

Poster # T-144 (Child, Ethics) **Exhibition Hall, 4th Floor**

Martinez-Torteya, Cecilia, MA[1]; Huston, Parker, BA[1]; Bogat, G., PhD[1]; Levendosky, Alytia, PhD[1]; Davidson, William, PhD[1]; Von Eye, Alexander, PhD[1]
[1]Michigan State University, East Lansing, Michigan, USA

Exposure to Intimate Partner Violence (IPV) increases risk for mental health problems among victims and their children. Despite evidence that psychological IPV is just as detrimental to women's mental health as physical IPV, few studies have explored its effects on children's functioning or tested mediating mechanisms. The present study tests the independent contributions of physical and psychological IPV to preschool children's internalizing and externalizing behaviors, as well as maternal mental health as a mediator of these relationships. Participants were 132 mother-child dyads (65 boys) who experienced physical and/or psychological IPV. Mothers completed measures of physical IPV and psychological IPV yearly near the child's 1st to 5th birthday. Mothers' reports of depression, anxiety, self esteem, and children's behavior at age 5 were used. SEM supported a fully mediated relationship; psychological violence predicted increased maternal mental health problems and mother's mental health predicted more child behavior problems. Physical IPV was not a significant predictor of maternal mental health or child functioning. The present findings challenge the notion of psychological IPV as a less severe form of abuse, and underscore the importance of addressing psychological IPV and maternal mental health in prevention and intervention efforts with IPV exposed children.

Social Network Strain Following Trauma and its Relationship to Behavior in High-Risk Situations

(Abstract #196509)

Poster # T-145 (Commun; Clin Res) **Exhibition Hall, 4th Floor**

Horsey, Katie, MA[1]; Lamoureux, Brittain, MA[1]; Hobfoll, Stevan, PhD[1]
[1]Kent State University, Kent, Ohio, USA

Trauma such as physical and sexual violence has been associated with risky sexual behavior that may lead to the transmission of HIV or other sexually transmitted diseases (Green et al., 2005; Rosenberg et al., 2001). Specifically, the effects of interpersonal trauma, and subsequent PTSD have been associated with unique relationship interaction problems that may heighten women's risk by depleting resources that influence negotiation skills. Trauma and PTSD may lead to loss of resources that women can bargain with, and also has been shown to cause a loss of social support, which may undermine empowerment, especially for African American women. Few studies have been able to examine such relationships with behavioral representations of high-risk sexual situations, making this study unique. For the present study, 300 inner-city women engaged in behavioral role-play scenarios designed to challenge their ability to negotiate high-risk sexual scenarios they experience in day-to-day life with intimate partners. Utilizing a structural equation model framework, it was theorized that trauma would lead to later loss of resources, as well as social network strain, causing later detriment to their behavioral negotiations in high-risk situations. Model fit indices suggest good model fit. Alternative models and specific parameters are discussed within.

The Experience and Impact of Police Torture in Chicago: First Findings

(Abstract #195935)

Poster # T-146 (Practice, Clin Res) **Exhibition Hall, 4th Floor**

Kenemore, Thomas, PhD[1]
[1]Masters Social Work Program, Chicago State University, Wilmette, Illinois, USA

This report presents first findings of a qualitative pilot study of the experiences of people affected by police torture. Subjects were involved in torture carried out in Chicago between 1973 and 2003. Findings describe and explain: the experience of torture and confession to a criminal act; the context surrounding the torture experience; and the lasting impact of the experience, as currently reported by the subjects. Experiences include being a target long before the torture episode, explicit and lasting memories of torture detail, and shameful silence afterword. The context for the study includes some enduring characteristics of the United States' national culture. The Chicago example of police torture is primarily

a story about white police officers torturing African American and Latino men. Implications for helping professionals are discussed.

Participant Alert: Individuals who have been tortured may find the material distressful.

No More Nightmares: How to Use Planned Dream Intervention to End Nightmares

(Abstract #195938)

Poster # T-147 (Practice, Mil Emer) **Exhibition Hall, 4th Floor**

Technical Level: Intermediate

Dexter, Beverly, PhD[1]

[1]*Naval Medical Center, Portsmouth, Chesapeake, Virginia, USA*

The 'No More Nightmares' poster for mental health professionals teaches participants how to use Planned Dream Intervention with their individual clients. Attendees will receive the basic training and additional case examples to further demonstrate the theory. Dr. Beverly Dexter, author of No More Nightmares: How to Use Planned Dream Intervention to End Nightmares, explains in this workshop that having distressing, disturbing or recurring content in dreams is normal when people have stressful experiences. Dr Dexter explains that dream work occurs at the neuron level, not at a conscious psychological level, and though dream content may be important, we should not try to "interpret" it. Many normal, non-violent individuals have violent or alarming content in their dreams after experiencing combat or other disturbing events. However, violent dreams do not create violent behavior; it is the other way around; when a person has disturbing experiences, they are likely to have 'aggressive' or alarming content in their dreams. The individual is supposed to be dreaming about the event in order to resolve the distress over time. With Planned Dream Intervention, your clients can learn to sleep through whatever the dreams are and wake up feeling rested in the morning. Most individuals who learn how to use this skill are no longer woken up by nightmares after the first night that they use the intervention. Regular practice of the Planned Dream Intervention skill will help people to sleep restfully through dreams, even in the future, with a resulting improvement in their health.

Coming Home: A Brief Overview of the Future Trauma Facing OIF/OEF Veterans

(Abstract #195939)

Poster # T-148 (Mil Emer, Media) **Exhibition Hall, 4th Floor**

Schmidt, Andrea, LMSW[1]

[1]*Hunter College, The City University of New York, New York, New York, USA*

According to current estimates, 1/3 of all Iraqi war veterans suffer from post traumatic stress disorder and an alarming 70% have been diagnosed with mild TBI. Many of these soldiers are also facing a life as an amputee and the trauma related to this loss of functioning. Although PTSD is not new to the healthcare field, but the treatment of this disorder coupled with traumatic brain injury is within this particular population.

When TBI is coupled with PTSD it is often hard to spot because TBI presents with many of the same symptoms, such as: increased anxiety, limited concentration, short attention span. (Kelly, 2004) Suffering from a TBI can be very debilitating for many of the troops especially when faced with other traumas such as being diagnosed with PTSD or facing the daunting task of physical therapy due to the loss of a limb. Depending on the severity and location of the TBI a person may have not only a loss of short term memory, but also be faced with speech and other motor impairments. Thus the re-teaching of simple tasks or even the ability to retain information is a chore.

Predictors of Acute and Persistent Symptoms of Dissociation in 2001 WTC Attack Disaster Workers

(Abstract #196414)

Poster # T-149 (Disaster, Prev EI) **Exhibition Hall, 4th Floor**

Wyka, Katarzyna, MA[1]**; Avedon, Jennifer, BS**[1]**; Malta, Loretta, PhD**[1]**; Weiner, Elliot, BA**[2]**; Cukor, Judith, PhD**[1]**; Difede, Joann, PhD**[1]

[1]*Cornell University, New York, New York, USA*

[2]*Fordham University, Bronx, New York, USA*

Trauma exposure can be associated with symptoms of dissociation. Although such symptoms do not necessarily increase PTSD risk, they are distressing and could potentially impede recovery from trauma and response to treatment. This study examined symptoms of dissociation in 1543 World Trade Center attack disaster restoration workers. Workers were evaluated 18 months post-exposure with structured clinical interviews that assessed trauma history, current (past month) symptoms of dissociation, and symptoms of dissociation at the time of exposure. The majority (62%) reported experiencing at least one clinically significant symptom of dissociation during exposure, and10% endorsed at least one clinically significant symptom during the assessment. Trauma history was significantly correlated with total dissociation symptom severity ($r=.15$, $p<.000$) and the most prevalent individual symptoms: derealization and reduced awareness of surroundings (for each correlation, $r=.13$, $p < .000$). After controlling for the initial dissociation symptom severity, trauma history significantly predicted the current severity of dissociation symptoms ($B=.25$, $p < .000$). The results suggest that peri-traumatic dissociation is associated with trauma history and may become chronic. Implications for screening and treatment are discussed.

Skills-Based Groups: Options for PTSD Treatment

(Abstract #195942)

Poster # T-150 (Clin Res, Mil Emer) **Exhibition Hall, 4th Floor**

Suniga, Sarah, PhD[1]**; Van Male, Lynn, PhD**[1]**; Wagner, Amy, PhD**[1]**; Boarts, Jessica, MA**[2]**; Armelie, Aaron, MA**[3]**; Delahanty, Douglas, PhD**[4]**; Lu, Mary, MD**[5]

[1]*Portland VA Medical Center, Portland, Oregon, USA*

[2]*Kent State University, Ravenna, Ohio, USA*

[3]*Kent State University, Stow, Ohio, USA*

[4]*Kent State University, Kent, Ohio, USA*

[5]*Portland Veterans Affairs Medical Center, Portland, Oregon, USA*

Identifying group formats to provide PTSD psychoeducation and coping skills is imperative in providing efficient and timely services to foster PTSD recovery. A variety of different group approaches with varied populations will be examined to identify multiple tools and resources to be used to provide empirically supported treatment delivery.

PTSD Symptom Management Groups With Veterans

The PTSD (Posttraumatic Stress Disorder) Symptom Management Group is particularly important considering the current influx of OEF/OIF (Operation Enduring Freedom/Operation Iraqi Freedom) veterans entering the VA mental health service. This PTSD skills-based group treatment provides specific and concrete techniques veterans can apply immediately for symptom relief. It is a 12-week manualized treatment targeting psychoeducation for PTSD and associated issues (trust, grief, anger, guilt, etc). Material regarding session by session teaching points and tools will be provided. Outcome evaluation data was conducted using pretest and posttest data for 70 veterans completing this group over the course of one year. Analyses demonstrated considerable decreases in PTSD symptoms and improvements in quality of life, which were found to be statistically significant.

Implementing a Seeking Safety Intervention in a Sample of People Living with HIV: A Pilot Study People living with HIV (PLWH) often report disproportionately high rates of traumatic experiences, and consequently, increased PTSD symptoms. Additionally, PTSD and

substance use/abuse are commonly comorbid, and have been associated with less than ideal medication adherence among PLWH. Seeking Safety (SS) therapy is designed to directly address PTSD and substance use comorbidity. The purpose of this ongoing pilot study is to investigate the efficacy of a group format SS therapy at treating PTSD and substance use. We hypothesized that participants receiving SS would exhibit lower PTSD symptoms and report less substance use as well as increased adherence to their HIV medications. PTSD symptoms, substance use, and adherence (both self-report and MEMS caps) are assessed at baseline (pre-intervention), post-intervention, and 3- and 6-months post-intervention. Findings will be discussed in terms of the benefits and shortcomings of a group format SS therapy in PWLH, and possible efficacy of SS at decreasing PTSD and substance use, and increasing medication adherence.

Imagery Rehearsal for Posttraumatic Nightmares in US Veterans
Over half of PTSD patients have frequent nightmares. Among psychotherapy approaches to treating recurrent nightmares, IRT currently has the broadest evidence base. IRT suggests that nightmares are learned behavioral responses to trauma. Patients learn to mentally rehearse changes to nightmare imagery while awake. We present a pilot study (n=15) and clinical examples to illustrate IRT implementation, course, and outcome in a group setting among male veterans. Group participants reported distressing, frequent nightmares and had previously completed an outpatient PTSD symptom management skills group or equivalent individual therapy. IRT was delivered in a six-week group intervention. Outcome measures were assessed pre and post-treatment and included a nightmare frequency questionnaire, the Nightmare Effects Survey, the Posttraumatic Stress Disorder Checklist (PCL-M), the Pittsburgh Sleep Quality Index (PSQI) and the Beck Depression Inventory (BDI-II). In this pilot study, posttraumatic nightmare frequency significantly decreased after IRT. IRT was not associated with significant improvement in overall subjective sleep quality or PTSD symptom severity. We anticipate that IRT deserves more systematic study in the veteran population.

Poster # T-151 (withdrawn)

Helping ER Nurses Coping With Posttraumatic Stress Symptoms – A "Tailor-Made" Solution

(Abstract #195949)

Poster # T-152 (EI, Mil Emer) **Exhibition Hall, 4th Floor**

Lavoie, Stephan, N.,PhD(C)[1]; Talbot, R. Lise, N., PSY.,PhD[2]; Mathieu, Luc, N.DBA[3]
[1]Universite de Sherbrooke, Sawyerville, Quebec, Canada
[2]Ecole des sciences infirmieres, Universite de Sherbrooke, Sherbrooke, Quebec, Canada
[3]Universite de Sherbrooke, Sherbrooke, Quebec, Canada

The work environment of ER nurses is a hard one. They regularly face critical incidents, and their personal coping mechanisms are insufficient to alleviate occupational stress, while organizational support is deemed insufficient. PTSD prevalence among ER nurses is higher than prevalence among the general population. The purpose of our study was to develop a support program that would be suited to ER nurses, in order to prevent PTSD symptoms. More specifically, we have described: the critical incidents they experience, the PTSD symptoms they exhibit, the support interventions they use, the additional support they need, and finally the interventions they would like to have access to. We used a qualitative-evaluative research model. Our sample consisted of twelve nurses. Data collection was conducted with a questionnaire, one-on-one interviews, and a focus group session. Content analysis allowed us to fulfill our objectives. The study's results will be present and discuss during the presentation.
In addition to describing their work context, this program represents a practical solution tailor-suited to ER nurses. In the second stage of this research, we will implement the program and measure its impacts on them.

Relationship Between Childhood Sexual Abuse and Adult BMI in an African American Sample

(Abstract #195950)

Poster # T-153 (Bio Med, Cul Div) **Exhibition Hall, 4th Floor**

Thomas, Katherine, BA[1]; Weiss, Tamara, MD[2]; Avasthi, Ranjan, MD[3]; Bradley, Rebekah, PhD[4]; Ressler, Kerry, MD, PhD[2]
[1]Department of Psychiatry and Behavioral Sciences, Emory University, Atlanta, Georgia, USA
[2]Emory University, Atlanta, Georgia, USA
[3]Morehouse University, Atlanta, Georgia, USA
[4]Emory University, Decatur, Georgia, USA

Research suggests a link between adult obesity and childhood trauma, particularly childhood sexual abuse (CSA). Previous research has focused on behavioral and psychological moderators; while the physiological mediators between obesity and child abuse are less understood. This study examined the relationship between obesity, child abuse, and HPA axis function in a subset of traumatized, economically disadvantaged African-American subjects (n=250). Data included: psychometric testing and assessment of past trauma exposure; body mass index (BMI), abdominal circumference (AC), and the AC/BMI ratio to measure obesity and central adiposity; dexamethasone (Dex) suppression test, including fasting and post-Dex measures of cortisol and ACTH; and lipid and glucose indicators of metabolic function. Participants with a history of CSA were more likely to be obese (BMI≥30) (p=.02) and morbidly obese (BMI_40) (p=.001). Childhood sexual abuse was also associated with an increased likelihood of having triglycerides >150 (p=.002; OR 3.1, CI [1.5 - 6.4]). After controlling for HPA function, PTSD and depressive symptoms, substance abuse, tobacco use, and gender, CSA-associated differences in the waist to BMI ratio remained significant (F=4.87, p=.035). Public health implications are discussed.

Distinct Vocabularies: Internal-State Language and its Relation to Forms of Childhood Trauma

(Abstract #195952)

Poster # T-154 (Child, Clin Res) **Exhibition Hall, 4th Floor**

Manczak, Erika, BA[1]; Cameron, Heather, BS[1]; Fezzey, Amanda, BS[1]; Manczak, Donna, PhD[2]; Muzik, Maria, MD[3]
[1]Psychiatry, University of Michigan, Ann Arbor, Michigan, USA
[2]Beaumont Hospitals, Grosse Pointe, Michigan, USA
[3]University of Michigan, Ann Arbor, Michigan, USA

Narrative creation can be a critical step toward overcoming childhood trauma. Yet different trauma histories may demand narrative approaches varies in attention to internal states. The goal of the current study is to assess whether attempts to narrate childhood physical or emotional abuse or neglect involve different cognitive and emotional processes. Study participants were administered the Childhood Trauma Questionnaire to retrospectively measure traumatic experiences incurred before the age of 16, and the Trauma Meaning-Making Interview to investigate progress toward constructing a meaningful narrative of the trauma. Transcripts were each coded by two independent raters for the frequency of 5 word categories pertaining to psychological processing: positive emotion, negative emotion, cognition, insight, and tentativeness. Analyses of preliminary data reveal that childhood physical abuse and physical neglect are correlated with the use of negative emotion words, whereas childhood emotional abuse is correlated with insight and causation language. These findings suggest that childhood trauma type impacts meaning-making at a profound linguistic and psychological level. Full results will be discussed, noting therapeutic implications.

Trauma Considerations in an Ethnically Diverse Sample of Domestic Violence Offenders

(Abstract #195955)

Poster # T-155 (Cul Div, Commun) **Exhibition Hall, 4th Floor**

Wray, Alisha M., MS[1]; Wiggins, Kathryn T., MS[1]; Hoyt, Tim, MS[1]; MaClean, Peggy C., MS[1]; Gerstle, Melissa, MS[1]

[1]Department of Psychology, University of New Mexico, Albuquerque, New Mexico, USA

Previous research has shown that trauma history may be related to particular aspects of domestic violence, including severity. Previous studies on this finding have been based upon primarily white samples, and it is unknown if this finding can be replicated in ethnically-diverse samples. Participants in this study were an ethnically diverse (23% white) sample of seventy-four men who were court-ordered into a domestic violence treatment program. Based on the typology developed by Holtzworth-Munroe and colleagues (1994), participants were grouped into family-only and borderline-dysphoric/generally violent-antisocial offenders using the MCMI-III. Participants also completed measures of trauma history (Traumatic Life Events Questionnaire; TLEQ) and PTSD symptoms (PTSD Screening and Diagnostic Scale; PSDS) as part of an intake assessment. Results revealed that borderline/antisocial offenders had significantly greater histories of trauma, as well as greater PTSD symptoms, than the family-only group. These group differences suggest that treatment outcomes may improve by tailoring interventions to offender subtypes and trauma history. Furthermore, these findings suggest that established offender typology can be replicated in ethnically diverse samples.

Secondary Victimization and Mental Distress Following Crime Related Death

(Abstract #195966)

Poster # T-156 (Clin Res, Ethics) **Exhibition Hall, 4th Floor**

Nakajima, Satomi, MD, PhD[1]; Shirai, Akemi, PhD[2]; Maki, Sachiko, MA[1]; Ishii, Ryoko, MA[3]; Tastuno, Bunri, MA[4]; Konishi, Takako, MD, PhD[5]

[1]Department of Adult Mental Health, National Center of Neurology and Psychiatry, National Institute of Mental Health, Kodaira, Tokyo, Japan
[2]Graduate School, Department of Human Science and Culture, School of Human Science, Musashino University, Musashino, Tokyo, Japan
[3]Center of Clinical Psychology, Musashino University, Musashino, Tokyo, Japan
[4]Faculty of Law, Kokushikan University, Setagaya, Tokyo, Japan
[5]Faculty of Human Science, Musashino University, Nishitokyo, Japan

Objective: This study examined how secondary victimization affected the mental health of the bereaved families of crime victims. Secondary victimization refers to the negative experiences of victims and their families, such as victim-blaming behaviors and negative attitudes of criminal justice personnel, community service providers, and associates after the crime.

Methods: Seventy-three bereaved family members of crime victims who were affiliated with 5 mutual self-help groups in Japan were interviewed more than 1year after their bereavement. We assessed distress caused by secondary victimization(the original measurement of which consisted of 16items measured using a 5-point Likert scale), PTSD symptoms (CAPS), depressive symptoms (BDI-2) and posttraumatic cognition (JPTCI).

Results: The attitudes of the perpetrator, perpetrator's family and criminal defense lawyer had the most adverse impact on the bereaved families. The severity of the distress caused by secondary victimization was significantly and positively correlated with the CAPS score, the BDI-2 score and the JPTCI score.

Conclusion: Secondary victimization might have an adverse effect on the mental health and posttraumatic cognition of the bereaved families. Criminal justice personnel and service providers should be mindful of the feelings of the bereaved families of crime victims to aid their recovery.

Screening for Posttraumatic Stress in Children: Combining Symptoms and Physiology

(Abstract #195967)

Poster # T-157 (Child, Prev EI) **Exhibition Hall, 4th Floor**

Kenardy, Justin, PhD[1]

[1]CONROD, School of Medicine, University of Queensland, Herston, Queensland, Australia

This study investigated the utility of combining the Child Trauma Screening Questionnaire (CTSQ) and children's heart rate (HR; emergency department and 24 hour post admission) to identify children likely to develop posttraumatic stress disorder (PTSD) symptoms at 1 and 6 months post-injury. Children completed the CTSQ within 2 weeks of injury. PTSD symptoms were assessed with the Anxiety Disorders Interview Schedule for *DSM-IV* for 79 children aged 7-16 years. A combination of the CTSQ plus HR (CTSQ-HR) was better than the CTSQ alone or HR alone at identifying children likely to develop PTSD symptoms. These findings suggest the CTSQ-HR screen may increase identification of children who are likely to develop PTSD symptoms, enabling the development of targeted prevention programs.

Trauma and Sexuality

(Abstract #195970)

Poster # T-158 (Practice, Clin Res) **Exhibition Hall, 4th Floor**

Scheffers, Mia, MSc[1]; Helleman, Ria, MA[2]

[1]Faculty of Human Movement Sciences, VU University, Amsterdam, Netherlands
[2]Centrum '45, Oegstgeest, Netherlands

Traumatic experiences, including non-sexual trauma, have a negative impact on sexual functioning and body attitude. Unfortunately, both clients and therapists tend to neglect the area of sexuality or find it difficult to speak about it freely.
In Centrum '45, the Dutch national center for victims of war and other forms of organized violence, a project was started to develop a treatment program on sexuality and body attitude and to gain more insight in the prevalence of problems in this field.
We developed a twelve weeks' group-therapy program focusing exclusively on this theme. Clients take part in this group program without interrupting their regular therapy. The same sex groups have a gender specific approach and combine body and movement psychotherapy with client-centered therapy.
In the workshop information will be presented based on five men groups and eight women groups. We will give an overview of the themes in our program and elaborate on the action- and experience-oriented verbal and nonverbal methods we use. Furthermore, we will present a short screening tool developed to provide us with more information on the prevalence of problems in the area of sexuality and body attitude in our target groups.

Posttraumatic Stress Disorder (PTSD) Among Correctional Staff: A Growing Problem

(Abstract #195974)

Poster # T-159 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Abdel Halim, Boudoukha, PhD[1]; Marc, Hautekeete, PhD[2]

[1]UFR de Psychologie, Laboratoire LabECD, Nantes, France
[2]UFR de Psychologie, Université de Lille - Charles-de-Gaulle, Villeneuve d'Ascq, France

Dangerousness is one of the mail characteristics that describe Prison settings. However, few are known about the repercussions of traumatic events, in terms of PTSD among correctional staff. PTSD is characterized by re-experiencing, avoidance and hyper-arousal symptoms. The question this study proposes to address is what causes PTSD among correctionalhe traumatic events staff. 370 correctional staff from 10 prisons participated in this study. They filled the French form of the Impact of Events Scale revised which contains 22 items measuring PTSD symptoms.

Victimizations are analysed through questions about the intensity of aggressions.

Prevalence of aggressions and traumatic events appear to be very common among the correctional professionals. We don't observe significant differences related to sex or profession on posttraumatic stress level (IES-R). Victimizations have significant effects on posttraumatic stress level ($F (3; 357) = 9.86$; $p < .0001$) whereas witnessing and aggression tend to have an effect ($p = .06$). Victimisations are common in our sample and increase significantly the severity of traumatic symptoms. We discuss CBT, stress management and debriefing.

Intimacy Modes Used by Sexual Assault Perpetrators and Male Peer Support Network Members in College

(Abstract #195975)

Poster # T-160 (EI, Ethics) **Exhibition Hall, 4th Floor**

Flack, Jr., William F., PhD[1]; Kanga, Michelle R., BA[1]; Dekeseredy, Walter S., PhD[2]

[1]Bucknell University, Lewisburg, Pennsylvania, USA

[2]University of Ontario Institute of Technology, Oshawa, Ontario, Canada

"Male peer support" (MPS) refers to social attachments among abusive men, and resources that such networks provide, that encourage and legitimate the abuse of women (Schwartz & DeKeseredy, 1997). In this study of college men, we examined intimacy patterns associated with sexual assault perpetration (SAP) and MPS network membership to identify the most frequent contexts in which these men engage in sexual behavior. Participants (n = 275 self-selected male students) completed an online survey of their behavior during college, including measures of SAP, MPS membership, and frequency of monogamous dating and/or four types of "hooking up" (sexual encounters without expectation of future commitment). MPS was a significant predictor of SAP. SAP was associated with one-time sexual encounters with strangers, and multiple sexual encounters with friends, whereas MPS network membership was associated with one-time sexual encounters with friends, and multiple encounters with acquaintances. These findings help further define characteristics of SAP, and may help to identify risky intimacy contexts for college women in the hooking-up culture.

The Long-Term Effects of Domestic Violence and Childhood Abuse on Women's Physical Health

(Abstract #196434)

Poster # T-161 (Bio Med, Clin Res) **Exhibition Hall, 4th Floor**

Mourad, Mariam, MA[1]; Levendosky, Alytia, PhD[1]; Bogat, G., PhD[1]; Davidson, William, PhD[1]; Basu, Archana, MA[1]

[1]Michigan State University, East Lansing, Michigan, USA

According to Herman's trauma theory, the experience of an interpersonal traumatic event can have long-lasting negative repercussions for the survivor. However, it is unclear if there are differences between types of trauma and specific physical health consequences. In the current study, participants' physical health, experience of domestic violence (current and past DV), and child abuse experience (CA: physical or sexual) was assessed; women were classified into one of four groups: DV only, CA only, DV and CA, and no trauma. Physical health consisted of lifetime major medical illnesses and health problems during the last 12-month period. 185 women in a longitudinal study of domestic violence participated in this assessment. MANOVA analyses indicated that the CA only and the DV and CA groups had more major medical illnesses and current health problems than the no trauma and DV only groups. This finding suggests that childhood abuse may have more pernicious effects on physical health than DV. However, past DV experiences also independently predicted current health problems. Thus, it is important to assess for childhood and adult experiences of trauma when treating physical health problems in adult women.

MDMA-Assisted Psychotherapy for the Treatment of PTSD, Current International Research

(Abstract #195977)

Poster # T-162 (Clin Res, Bio Med) **Exhibition Hall, 4th Floor**

Mithoefer, Michael, MD[1]

[1]Psychiatry, Private practice clinical research, Mount Pleasant, South Carolina, USA

Despite the effectiveness of several existing treatments for PTSD, a significant percentage of patients remain treatment resistant. The search for more effective treatments for these patients is crucial. The first phase II clinical trial of MDMA-Assisted Psychotherapy for treatment resistant PTSD will be completed in July 2008 in the US. Similar trials for crime and terrorism related PTSD are currently ongoing in Switzerland and Israel. In these studies MDMA is administered under direct supervision in conjunction with psychotherapy sessions. Non-drug therapy sessions for preparation and integration of the experience are essential features. The principal investigator of the US study will present his final results as well as preliminary results of the Swiss and Israeli studies. He will explain the therapeutic method and illustrate it with clinical vignettes. The encouraging results of these pilot studies suggest a promising future for this model of drug-assisted psychotherapy.

The Society's Annual Meeting (A First-Time Attendee's Perspective)

(Abstract #195981)

Poster # T-163 (Media, Assess Dx) **Exhibition Hall, 4th Floor**

Mohamed, Omar, MD[1]

[1]Psychiatry, University of Tennessee, Memphis, Tennessee, USA

This abstract represents a feedback about the ISTSS annual meeting as viewed through the eyes of a first time attendee. It will discuss the aspects that were somewhat lacking at the meeting, and some brainstorming ideas as how to may improve these aspects to make the meeting more easy to navigate and enjoy, especially for students and first time attendees.

Poster # T-164 (withdrawn)

Child Abuse, Dissociation, and Adult Attachment: Mediators and Moderators of Partner Violence

(Abstract #195986)

Poster # T-165 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Sullivan Kalill, Kathleen, BA[1]; Conrad, Sheree, PhD[1]

[1]Clinical Psychology, University of Massachusetts at Boston, Boston, Massachusetts, USA

Previous research has found a strong connection between a reported history of childhood abuse and use of violence in adult intimate relationships. In addition, dissociation and an insecure adult attachment style have been implicated as both consequences of childhood abuse and risk factors for adult intimate partner violence (IPV). A survey study of 150 men at an urban commuter university examined whether the trauma of childhood physical and/or sexual abuse affects the development of a dissociative coping style and an insecure adult attachment style and whether the combined impact of these factors cumulatively impacts the risks for perpetration of IPV in adulthood. In addition, this study seeks to add to our understanding of the mechanisms by which dissociation and adult attachment style affect the relationship between severity of childhood abuse and adult IPV; adult attachment style is examined as a moderator between childhood abuse and IPV and dissociation is examined as a mediator. Findings will be discussed in terms of implications for future research and prevention and violence intervention programs.

Health and Quality of Life in PTSD: What is the Impact of Co-Occurring Depression?

(Abstract #195990)

Poster # T-166 (Bio Med, Assess Dx) **Exhibition Hall, 4th Floor**

Fabritius, Jennifer S., BA[1]; Doane, Lisa S., PhD[1]; Echiverri, Aileen M., BS[2]; Kahana, Shoshana Y., PhD[3]; McDavid, Joshua D., MD[2]; Zoellner, Lori A., PhD[4]

[1]Department of Psychology, Case Western Reserve University, Cleveland, Ohio, USA
[2]Department of Psychology, University of Washington, Seattle, Washington, USA
[3]Division of Developmental Translational Research, National Institute of Mental Health, Bethesda, Maryland, USA
[4]Dept of Psychology, University of Washington, Seattle, Washington, USA

Posttraumatic stress disorder (PTSD) and major depressive disorder (MDD) are independently associated with poor physical health and impaired quality of life (e.g., Pyne et al., 1997; Zatzick et al., 1997; Zayfert et al., 2002). Moreover, PTSD and MDD are commonly co-occurring (e.g., Kessler et al., 1994), and the presence of both disorders (PTSD+MDD) may lead to increased health problems and impairments in functioning (Clum et al., 2000; Shalev et al., 1997). In the current study, we will examine physical health status and functioning in those with PTSD alone compared to PTSD+MDD. The sample consists of 173 participants in a RCT with a primary diagnosis of PTSD; 53% had currently co-occurring MDD. More severe symptoms for both depression and PTSD were associated with impaired functioning, physical functioning, and role limitations due to health problems. When compared to those without MDD, those with current PTSD+MDD had more impairment in functioning. Demographic, health, and functioning-related predictors of PTSD/PTSD+MDD will be identified. A better understanding of the potential impact co-occurring MDD may have on PTSD with regard to health and quality of life may provide further insight into the impairment associated with this specific comorbidity.

The Psychological Aftermath of Terrorism: The 2001 New York City World Trade Center Attack

(Abstract #195998)

Poster # T-167 (Disaster, Practice) **Exhibition Hall, 4th Floor**

Tramontin, Mary, PsyD[1]; Halpern, James, PhD[2]

[1]PTSD Clinic, James J. Peters VAMC, New York, New York, USA
[2]State University of New York at New Paltz, New Paltz, New York, USA

This poster explores the psychological aftermath of terrorism by examining what transpired in New York City after the World Trade Center attack. It is a summary of clinical observations, case examples and relevant disaster research findings derived from a seven years later vantage point. This presentation reflects the clinical experiences of two psychologists who helped to coordinate some of the provision of mental health services to those affected by this disaster and who also provided direct assistance to survivors, to the family members and colleagues of those who died, to respondent emergency service providers and to others affected by the devastation. In this presentation we will describe and discuss the psychological impact of this event. We will: 1.) provide a context for understanding the nature of traumatic events and terrorism specifically, 2.) reflect the range of subsequent psychological responses and interventions, 3.) outline current interventions that are evidence informed and are done early, intermediate and long-term after an event, 4.) present several case studies illustrating these practices and 5.) offer reflections and recommendations.

Pharmacotherapy in Prevention and Treatment of PTSD

(Abstract #195999)

Poster # T-168 (Bio Med, Practice) **Exhibition Hall, 4th Floor**

Marvasti, Jamshid, MD[1]

[1]Psychiatry, Manchester Memorial Hospital, Manchester, Connecticut, USA

The utlization of pharmacotherapy and the possible prevention of PTSD as an aftermath of terrror will be discussed. Current aspects of medication and the possible prevention of the negative impact of psychic trauma will be explored. The definitions of trauma, and its short and long- term negative impacts are explained in biochemical and anatomical terms. The effects of emotional trauma/stress and the resultant changes in the brain are presented. Researchers once reported that it seemed that "something emotional," no matter how devastating it could be, would have an impact only on the "software" of the brain's "computer." However, scientific literature now points toward damage and changes in the anatomy of the brain (hardware) as well as an alteration of biochemical/hormonal pathways. The utilization of medications such as SSRIs, SNRIs, mood stabilizers and adrenergic blockers may help prevent the development of these biochemical and anatomic structural changes in the brain. Yet, the treatment of trauma is multifaceted, and pharmacotherapy is only one aspect needed for overall improvement.

Attachment, Personality, and Posttraumatic Stress Symptoms in a Traumatized Urban Population

(Abstract #196000)

Poster # T-169 (Practice, Ethics) **Exhibition Hall, 4th Floor**

Ortigo, Kile M., MA[1]; Castleberry, Joshua J., BS[2]; Guarnaccia, Clifford, PhD[1]; Ressler, Kerry, MD, PhD[3]; Bradley, Rebekah, PhD[4]

[1]Department of Psychology, Emory University, Atlanta, Georgia, USA
[2]Psychiatry and Behavioral Sciences, Emory University, Atlanta, Georgia, USA
[3]Emory University, Atlanta, Georgia, USA
[4]Emory University, Decatur, Georgia, USA

Traumatic experiences have been linked to development of multiple forms of psychopathology, including PTSD and maladaptive personality traits. One potentially important variable related to understanding connections between trauma exposure and characteristics of personality is attachment style. Although relationships between childhood trauma and attachment and between attachment and risk for development of PTSD in adulthood have been described theoretically, relatively little research has addressed these constructs simultaneously. Present data are drawn from an NIMH-funded study investigating environmental and genetic risk factors for PTSD in low-SES, primarily African American individuals seeking care at a public urban hospital. Hierarchical regression analyses (current n = 88) indicated personality traits (e.g., Negative Temperament) predicted frequency of PTSD symptoms beyond that explained by level of childhood or adult trauma exposure ($p < .001$). Moreover, interviewer-reported attachment ratings explained variance in PTSD symptoms above that accounted for by trauma exposure or personality traits ($p < .01$). Based on these data, we present clinical, public policy, and theoretical implications for understanding and preventing negative impacts of trauma in this highly traumatized but under-studied and under-served population.

Policies, Programs and Practices That Foster Ready to Work Skills in Wounded Global War on Terror Veterans With PTSD

(Abstract #196003)

Poster # T-170 (Practice, Commun) **Exhibition Hall, 4th Floor**

Garrick, Jackie, MSW[1]; Williams, Mary Beth, PhD[2]; Clark, Steven, BS[3]

[1]United States Congress, Silver Spring, Maryland, USA
[2]Private Practice, Warrenton, Virginia, USA
[3]Morale, Welfare and Recreation, Department of Defense, Alexandria, Virginia, USA

For injured or ill soldiers returning from the Global War on Terror, the ability to go back to work has been a crucial issue in recovery. In many cases, severely injured or traumatized veterans are not ready to return to the work environment, nor are they ready for vocational rehabilitation. Therefore, other transitional programs have been developed to help prepare wounded service members to gain the physical and emotional skills to reintegrate into their communities. Occupational and recreational therapies have aided in refreshing the minds and bodies of veterans through activities that stimulate, revive and restore a sense of competency, usefulness and functionality. Ready to work strategies build on physical strengths, abilities, and skills to overcome the debilitating effects of traumatic memory on the mind. Presenters will focus on the overall policies and practices that are conduits for readying to work, the programs and projects wounded warriors are actively participating in, and the ready to work treatment issues.

A Prospective Study of Predictors of Depressive Symptoms in Police

(Abstract #196006)

Poster # T-171 (Mil Emer,Prev El) **Exhibition Hall, 4th Floor**

Wang, Zhen, MD[1]; Inslicht, Sabra, PhD[2]; Metzler, Thomas, MA[2]; Neylan, Thomas, MD[2]; Marmar, Charles, MD[2]

[1]Shanghai Mental Health Center, Shanghai, China
[2]University of California San Francisco, San Francisco, California, USA

This prospective longitudinal study was designed to examine predictors of depressive symptoms in police service. 119 police completed questionnaires on baseline depressive symptoms, childhood trauma, neuroticism and self-worth during academy training. Current depressive symptoms, current PTSD symptoms, critical incident exposure, negative life events and work stress were assessed after 1 year of police service. Hierarchical linear regression analysis was conducted to examine six candidate predictors of current depression. After controlling for baseline depression and current PTSD symptoms, greater childhood trauma exposure, lower self-worth during training and greater perceived work stress in police service were significant predictors of greater depressive symptoms at 12 months. Neuroticism, negative life events and critical incident exposure were not significant predictors in the final model. The results indicated the presence of depressive symptoms at one year of police service were partly independent from PTSD symptoms. Childhood trauma exposure and self-worth may be important variables to screen as risk factors for duty-related depression and police officers may benefit from work stress management during police service.

Poster # T-172 (withdrawn)

The Impact of Kinship on Mental Health Among Japanese Bereaved Families by Homicide

(Abstract #196012)

Poster # T-173 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Shirai, Akemi, PhD[1]; Nakajima, Satomi, DR,PhD[2]; Maki, Sachiko, MA[2]; Tatsuno, Bunri, MA[3]; Konishi, Takako, DR,PhD[4]

[1]Graduate School, Department of Human Science and Culture, School of Human Science, Musashino University, Musashino, Tokyo, Japan
[2]Department of Adult Mental Health, National Center of Neurology and Psychiatry, National Institute of Mental Health, Kodaira, Tokyo, Japan
[3]Faculty of Law, Kokushikan University, Setagaya, Tokyo, Japan
[4]Fuculty of Human Science, Musashino University, Nishitokyo, Tokyo, Japan

Background: Few studies have been conducted on the psychological consequences on bereaved families of a fatal crime victim. We examined, through a self-reported measure, whether differences in the situation surrounding the deceased victim would have any effect on the mental health of bereaved families of the violent crime victim.

Methods: 151 bereaved family members of the victims of homicide and accidental death who were affiliated with self-help groups in Japan were assessed regarding depressive/anxiety symptoms (K10), posttraumatic symptoms (IES-R), complicated grief (ITG), social support and secondary victimization.

Results: Forty-one percent of the subjects were at the high-risk level in K10, 77.5% in IES-R and 18.5% in ITG. The significant differences of all kinship groups (conjugal, child, sibling/parental, other kinship) were revealed within the K10 score($F(3,137)=10.63, P<.001$) ITG($F(3,136)=9.88, P<.001$), IES-R intrusion ($F(3,138)=6.33, P<.001$) and IES-R hyperviligance ($F(3,138)=4.18, P=.007$) with ANOVA. Parents who have suffered the loss of a child have significantly more psychological distress than sibiling/parental, other kinship by the Scheffe test.

Conclusions: In particular, parents who have lost their child through violent death should be treated simultaneously for PTSD, depressive symptoms and complicated grief.

Longitudinal Analysis of Memory for Trauma and Symptoms of PTSD

(Abstract #196013)

Poster # T-174 (Assess Dx, Practice) **Exhibition Hall, 4th Floor**

Morris, Adam, BA[1]; Sledjeski, Eve, PhD[2]; Fallon, William, MD[3]; Spoonster, Eileen, RN[3]; Delahanty, Douglas, PhD[1]

[1]Kent State University, Kent, Ohio, USA
[2]Wesleyan University, Middletown, Connecticut, USA
[3]Summa Health System, Akron, Ohio, USA

Research on adult trauma patients has shown that memory for the traumatic event can serve as a buffer for developing PTSD symptoms (PTSS). The present study extends earlier studies (Flesher, et al., 2001) by examining the impact of memory for a traumatic event on PTSS at four time points. 362 MVA victims completed the Impact of Event Scale-Revised (IES-R) in-hospital and the Clinician Administered PTSD scale (CAPS) at 6-weeks and 6- and 12- month follow-ups. Participants with complete memories of the event did not differ on in-hospital total IES-R scores from participants with incomplete memories after controlling for gender and injury severity, $F(3,358) = 3.72$, ns. However, after controlling for gender, injury severity and current major depression, those with any trauma-specific memory deficits reported more PTSD symptoms ($M = 31.30$, $SD = 24.51$) than those with full memory for the event ($M = 21.31$, $SD = 18.86$), at 6 weeks post-trauma, $F(4, 244) = 6.13$, $p < .05$. Results persisted at the 6-month, $F(4,164) = 5.35$, $p < .05$, and 12-month follow-ups, $F(4,137) = 4.56$, $p < .05$. Findings will be discussed in terms of application to specific cognitive models of PTSD and with respect to divergent prior findings.

A Problem With Psychotherapy "Packages": An Example From Cognitive Processing Therapy (CPT)

(Abstract #196014)

Poster # T-175 (Mil Emer, Clin Res) **Exhibition Hall, 4th Floor**

Lipke, Howard, PhD[1]

[1]DVA Medical Center, North Chicago, Illinois, USA

The complexity of psychotherapy "packages" may make individual elements difficult to separate and evaluate. An element of the DoD/VA manualized version of CPT for treating combat related PTSD (Resick et al., 2007) was amenable to analogue testing, and was examined. This element provided specific suggested responses intending to "deescalate" the dialogue when the therapist is flustered after being asked about having combat experiences. In this study, a survey asked combat veterans, in a residential PTSD treatment program, how they might respond to some of the manual suggestions, as well as to more direct approaches to the question. Twenty-four subjects responded to the survey. Only responses deflecting the question (e.g. "What is the point of asking that question?") received any "very negative" ratings, the first two of the CPT suggestions receiving 6 and 4 respectively. Only a response which answered the question directly received no responses of "negative" or worse. Complete data is reported, the limitations and implications of the study are addressed.

Profile of Posttraumatic Distress in Traumatized Youth

(Abstract #196015)

Poster # T-176 (Assess Dx, Child) **Exhibition Hall, 4th Floor**

Rachamim, Lilach, MA[1]; Helpman, Liat, MA[1]; Shafran, Naama, MA[1]; Daie-Gabai, Ayala, MA[1]; Foa, Edna, PhD[2]; Gilboa-Schechtman, Eva, PhD[1]

[1]Department of Psychology, Bar Ilan University, Ramat Gan, Israel
[2]University of Pennsylvania, Philadelphia, Pennsylvania, USA

The profile of post traumatic distress (PTD) in pediatric victims of single-event traumas was examined. Youth (age 8-19) completed the children post traumatic symptom scale (CPSS, Foa, et al, 2001), and measures of depression and anxiety, as well as clinical interviews. Sensitivity of CPSS was supported by higher levels of CPSS associated with the full diagnosis of PTSD; specificity of CPSS was supported by higher levels of PTD exhibited by diagnosed PTSD sufferers as compared to trauma victims diagnosed with other disorders. Pediatric PTSD symptom profile was best represented by two symptom clusters: Intrusion/Active Avoidance/Arousal and Numbing/Passive Avoidance. Results support the centrality of intrusion/active avoidance and the peripherality of numbness/passive avoidance in clinical presentation of PTSD in youth. Age and gender were not associated with differences in symptom structure or severity. While no difference in distress emerged between specific trauma types, results suggest that traumas involving interpersonal violence are associated with higher levels of PTD than other traumas. CPSS emerged as a valid screening tool for PTSD in youth. Implications for the nosological structure of posttraumatic symptoms in youth are discussed.

Tackling Traumatic Stress Among Firefighters in a Preventative Fashion: Incentives for Organizations

(Abstract #196016)

Poster # T-177 (Mil Emer,Prev EI) **Exhibition Hall, 4th Floor**

Gray, Lori K., MA[1]; Jackson, Dennis L., PhD[1]

[1]Psychology Department, University of Windsor, Windsor, Ontario, Canada

Emergency service providers experience traumatic events within the context of routine job duties. Accordingly, recent research has begun to elucidate the means through which emergency service providers' organizational environment might impact the development of traumatic stress. These findings suggest that efforts to prevent the development of traumatic stress might address the organizational environment. Whereas the impetus for addressing traumatic stress in a preventative fashion would be to maintain the psychological well-being of emergency service providers, it is unclear to what extent such efforts might benefit emergency service organizations. The objective of the study was to ascertain the potential impact that traumatic stress might have upon firefighters' absenteeism and factors associated with employee retention. The study utilized self-report data obtained from an anonymous internet survey conducted with Canadian firefighters. Greater traumatic stress was associated with increased absenteeism and decreased job satisfaction and commitment to their organization. The implications for addressing traumatic stress from a preventative standpoint will be discussed.

Memory Consistency for Peritraumatic Reactions in Acute and Chronic PTSD

(Abstract #196017)

Poster # T-178 (Clin Res,Prev EI) **Exhibition Hall, 4th Floor**

David, Annie-Claude, BA[1]; Akerib, Vivian, BA, MA[2]; Brunet, Alain, PhD[3]

[1]University of Québec in Montréal, Montréal, Québec, Canada
[2]Douglas Hospital Research Center, Montréal, Québec, Canada
[3]McGill University, Montréal, Québec, Canada

The literature on the consistency of memory for trauma indicates that intentionally recalled trauma memories may show variability across time. We investigated longitudinally the memory of trauma-exposed individuals with respect to their remembered reactions at the time of trauma. Trauma-exposed participants with chronic PTSD (n=23) and with acute PTSD in remission (n=29) filled out the Peritraumatic Distress Inventory and the Peritraumatic Dissociative Experience Questionnaire within the first month of trauma exposure as well as within 1 to 6 months after the event. A strong test-retest correlation was found in the group that remitted from Acute PTSD (PDI: r=0.66; PDEQ: r=0.69) but not for the chronic PTSD group (PDI: r=-0.006; PDEQ: r=0.301). A significant difference was also found between the correlation's coefficients for the PDI (p=0.007) and a trend was found for the PDEQ (p=0.0893). The results suggest that trauma-related memories are unstable for chronic PTSD individuals only. Such results extend previous findings on variability in trauma memories and may provide further information about the factors implicated in the disorder's recovery.

Longitudinal PTSD Symptom Cluster Changes in Iraq-Deployed and Non-Deployed Army Soldiers

(Abstract #196026)

Poster # T-179 (Mil Emer, Assess Dx) **Exhibition Hall, 4th Floor**

MacDonald, Helen, PhD[1]; Proctor, Susan, DSC[2]; Vasterling, Jennifer, PhD[3]

[1]VA Boston Healthcare System, Boston, Massachusetts, USA
[2]Research Service, VA Boston Healthcare System, Boston, Massachusetts, USA
[3]Psychology Service, VA Boston Healthcare System, Boston, Massachusetts, USA

Literature investigating the natural course of PTSD following trauma exposure has found differential symptom trajectories by cluster, with reexperiencing and hyperarousal symptoms emerging first and giving rise to avoidance and emotional numbing symptoms. Whereas reexperiencing symptoms appear to naturally remit over time, hyperarousal and emotional numbing symptoms remain constant or increase, predicting a chronic course of PTSD. To date, no research has included pre-trauma exposure PTSD symptoms in analyses charting the trajectory of symptoms over time. The Neurocognition Deployment Health Study is a prospective, cohort-controlled study examining neuropsychological

outcomes of deployment to Iraq. To address these questions, Time 1 (pre-deployment) and Time 2 (post-deployment for deployers; post-garrison for non-deployers) PTSD Checklist data were analyzed in 779 Iraq-deployed soldiers and 315 non-deployed soldiers. Generalized estimating equations with deployment revealed that reexperiencing (β=1.42, p<.0001), avoidance (β=0.351, p<.001), and arousal (β=1.72, p<.0001) scores increased over time as a function of deployment. Numbing symptoms did not change as a function of deployment (β=.104, p=.458). These findings suggest that deployment exerts stronger initial influences on reexperiencing, avoidance, and arousal symptoms, as compared to numbing.

PTSD and Pathological Gambling

(Abstract #196029)

Poster # T-180 (Assess Dx, Practice) **Exhibition Hall, 4th Floor**

Najavits, Lisa, PhD[1]; Korn, David, MD[2]; Meyer, Tamar, BS[2]; Johnson, Kay, MSW[3]; Jansma, Margreet, BA[4]
[1]VA Boston Healthcare System, Boston, Massachusetts, USA
[2]University of Toronto, Toronto, Ontario, Canada
[3]Treatment Innovations, Brookline, Massachusetts, USA
[4]VA Boston, Boston, Massachusetts, USA

We report results of a study to compare three groups (n=35 each, 105 total): individuals with pathological gambling disorder (PG), posttraumatic stress disorder (PTSD) alone, and comorbid PTSD plus PG. This cross-sectional study was designed to help better understand the etiology, clinical presentation, and sequelae of comorbid PTSD and PG. Measurement was in four categories: psychopathology (including a complete Axis I and Axis II *DSM-IV*R interview assessment); functioning (e.g. employment status, social relationships, health status); attitudes toward gambling; other cooccurring addictions; and family and trauma history. We also conducted a qualitative, video-based interview to explore themes. Results indicate greater severity and worse functioning by those with the dual diagnosis compared to those with either disorder alone; prominence of comorbid Axis I and II disorders among all three groups (especially substance use disorder); and for PG groups, themes of escape, dissociation, and hopelessness. Findings are discussed in terms of further research to help understand the development of PTSD and PG, implications for clinical practice, and measurement issues.

Stressors of War: Listening to Operation Enduring Freedom and Operation Iraqi Freedom Veterans

(Abstract #196031)

Poster # T-181 (Mil Emer, Res Meth) **Exhibition Hall, 4th Floor**

Scheiderer, Emily, BA[1]; De Blank, Gabriel, MED[1]; Vogt, Dawne, PhD[2]; Kelly, Megan, PhD[3]
[1]National Center for PTSD, VA Boston Healthcare System, Boston, Massachusetts, USA
[2]Boston University; National Center for PTSD, VA Boston Healthcare System, Boston, Massachusetts, USA
[3]Butler Hospital, Warren Alpert Medical School of Brown University, Providence, Rhode Island, USA

Military deployments present individuals with an array of mental and physical stressors, creating a context in which factors of risk and resilience assume critical importance (Bartone, 1999). As military conflicts differ, so too do their associated deployment stressors (Wolfe et al., 1993). To appropriately address OEF/OIF veterans' mental and physical healthcare needs, and to guide future research, we need an updated understanding of the stressors unique to these conflicts. The present study used focus groups to examine the deployment experiences of OEF/OIF veterans. 29 participants in 6 focus groups responded to a moderator's questions and to each others' comments, fostering in-depth discussions enriched by diverse perspectives. Coders reviewed partial transcripts and identified comments related to themes of risk and resilience. With minor modifications (e.g., changes in language), many themes that emerged echoed those identified by prior veteran cohorts (e.g., GWI veterans: King et al., 2006). Novel themes and substantial differences also emerged. Particularly salient stressors included: perceived lack of preparedness, pressures of nontraditional warfare, concerns about family, and difficulties with postdeployment reintegration.

Participant Alert: The inclusion of written and/or quoted descriptions of distressing experiences encountered during military deployments may distress some attendees.

Sudden Estrangement of Adult Children

(Abstract #196032)

Poster # T-182 (Practice,Prev EI) **Exhibition Hall, 4th Floor**

Albeck, Isabelle, MED[1]; Toler, Jane, PhD[2]; Brown, Margaret, BS[3]
[1]Private Practice, Waban, Massachusetts, USA
[2]The Family Place, Dallas, Texas, USA
[3]Home, Waban, Massachusetts, USA

There is a silent epidemic of adult children who are 'divorcing' their parents and refusing contact with them. Despite having been 'good enough' parents who provided love and support, these parents are being told all of a sudden: 'I am done with you'. The parents' trauma is compounded by a lack of knowledge in the professional community and the lack of social support due to the invisibility of the estrangement. The predictable stages parents go through will be presented as well as aspects of reconciliation. The mother of a 35 year-old who estranged himself and a grandmother cut off from her grandchildren as a result of the estrangement of her adult daughter, will describe their experiences and coping strategies. The facilitator of a support group for such parents will discuss issues of estrangement and present a model based on her pioneering work.

How can clinicians reduce the impact of trauma on the parents and the other siblings? What can clinicians do when grandchildren are involved? Can anything be done to better understand or influence the behavior of these adult children?

Gender, Trauma and PTSD Among Undergraduates

(Abstract #196035)

Poster # T-183 (Assess Dx,Prev EI) **Exhibition Hall, 4th Floor**

Ouimette, Paige, PhD[1]; Read, Jennifer, PhD[2]; White, Jacqueline, PhD[3]; Colder, Craig, PhD[2]; Tirone, Vanessa, BA[4]
[1]Syracuse VA Medical Center, Syracuse, New York, USA
[2]University at Buffalo, Buffalo, New York, USA
[3]University of North Carolina, Greensboro, North Carolina, USA
[4]Veterans Affairs Medical Center, Syracuse, New York, USA

Community studies consistently find that women are twice as likely to have PTSD as men, as well as report more exposure to specific types of trauma such as rape. College is a time of high-risk for trauma exposure. Yet despite this, little information is available about trauma and PTSD among students, especially regarding gender comparisons. This study examined these issues among 3,014 incoming students at two large public universities. Participants completed measures of trauma and PTSD via the internet or on paper. Results indicated that females reported more trauma than males (74% vs. 54%). Women reported more exposure to all event types than men with the exception of combat. Women reported more PTSD than men (11.3% versus 5.4%) and were more at risk for PTSD than male students following sudden death of a loved one, "other" trauma, physical violence, and unwanted sex (the latter two at trend levels). To our knowledge, these are the first data to examine Criterion A trauma and PTSD in a representative sample of college freshmen. Findings suggest that while female gender conveys a particular risk, a high proportion of female and male students enter the university setting with a trauma histories, as well as significant PTSD.

Dream Group Therapy for Combat PTSD

(Abstract #196038)

Poster # T-184 (Practice, Clin Res) **Exhibition Hall, 4th Floor**

Dow, Bruce, MD[1]

[1]*Psychiatry, University of California, San Diego, Cambridge, Massachusetts, USA*

A hospital-based group therapy program was established for Vietnam Veterans (both inpatients and outpatients) with combat-related posttraumatic stress disorder (PTSD). Weekly group sessions were led by the author and a few staff members. Each session was devoted to a single patient, whose recurrent dream was written on a blackboard. The dream text and group comments were recorded in a log. The dreamer indicated dream frequency, triggers, feelings aroused, variations in content, etc. The group then engaged in a brainstorming process to devise ways of revising the dream. The dreamer selected changes that would be helpful to him, and was then instructed to rehearse the revised dream before going to sleep. Feedback from previous sessions (provided at the beginning of each session) indicated that most dreams went away or were substantially improved following a single group session. Attempts to reproduce the dream group in an office setting were unsuccessful. A hospital-based setting seems optimal to contain the emotions aroused in group members by anxiety-provoking combat nightmares of other group members.

Participant Alert: Some dream content may contain graphic combat-related violence.

Post Incident Interventions for Firefighters

(Abstract #196040)

Poster # T-185 (Mil Emer, Clin Res) **Exhibition Hall, 4th Floor**

Jeannette, James, BA[1]**; Scoboria, Alan, PhD**[1]

[1]*Psychology, University of Windsor, Windsor, Ontario, Canada*

Effectiveness of Critical Incident Stress Debriefing (CISD) as a tool remains, at best, inconclusive. Yet in many locales CISD is mandatory for Emergency Services workers. To date, no study has asked firefighters about their preferences for psychological intervention following traumatic events. To examine this, a survey was conducted with 142 members (54%) of the Windsor (Ontario) Fire and Rescue Service. Firefighters were presented with five scenarios of varying traumatic intensity, and rated the desirability for voluntary post-incident interventions (CISD, individual debriefing, informal discussion, and no intervention) for each. Results indicated that firefighters expressed interest in working with post-event reactions within their peer group across event, with accompanying desire for voluntary formal intervention as event severity increased. Expected relationships between intervention choice, prior CISD experience, and years of service as a firefighter were not upheld. Implications of the findings are discussed.

Masculinity Predicts Social Support Beyond Symptoms of Posttraumatic Stress in Male Veterans

(Abstract #196041)

Poster # T-186 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Morrison, Jay, MA[1]**; Mahalik, James, PhD**[1]

[1]*Department of Counseling, Developmental, and Educational Psychology, Boston College, Chestnut Hill, Massachusetts, USA*

Criterion C-5, feelings of detachment or estrangement from others, captures the experience of social alienation that often accompanies Posttraumatic Stress Disorder (PTSD). This is particularly concerning as social support is a predictor of a variety of variables related to health. Adherence to social norms for traditional masculinity has been shown to relate to a variety of important health outcomes as well. However, the extent to which masculinity relates to both social support and symptoms of PTSD remains unstudied. This study examined scores on the Posttraumatic Stress Disorder Checklist - Military Version (PCL-M), the UCLA Loneliness Scale, the Interpersonal Support Evaluation List (ISEL), and the Conformity to Masculine Norms Inventory (CMNI-22) from 197 veterans seeking treatment at the VA Boston Healthcare System. Regression analyses confirmed that conformity to masculine norms predicted significant variation in both loneliness and social support beyond that accounted for by symptoms of PTSD alone. This preliminary data suggests that a gender-sensitive approach may be beneficial to the treatment of PTSD as well as for addressing the health concerns of veteran men.

Evaluating the Satisfaction and Learning Impact of the OSISS Peer Helper Training Module

(Abstract #196045)

Poster # T-187 (Media, Mil Emer) **Exhibition Hall, 4th Floor**

Shields, Norman, PhD[1]**; Cargnello, Juan, MPS**[1]**; Montplaisir, Yves, MED**[1]

[1]*National Centre for Operational Stress Injuries, Ste. Anne's Hospital, Veterans Affairs Canada, Ste-Anne-de-Bellevue, Quebec, Canada*

Veterans Affairs Canada (VAC) and National Defence Canada co-sponsor a unique national peer helper organization known as the Operational Stress Injury Social Support (OSISS) program. VAC's National Centre for OSIs supports training of OSISS coordinators and volunteers that provide peer support to active Canadian forces members, veterans, and family affected by operational stress injuries (OSIs). An OSI is any persistent psychological difficulty resulting from operational duties performed while serving in the Canadian military. Peer support is an essential element to recovery and relevant peer training is needed.

The current paper describes the 3-day OSISS peer helper training module (i.e., manualized & experiential learning components); summarizes the training satisfaction results from 10 training sessions provided to varied peer helpers (n = 108); and summarizes 2-month follow-up learning impact survey results. Quantitative (i.e., likert scale) and qualitative data (i.e., comments) are presented. Training satisfaction results indicated a high rate of endorsement (> 90% in agreement) on training objectives, content and methodology. Recommendations included more practice time (e.g., role play). The impact evaluation is in progress and will be presented. The results lend preliminary support to the validity of this training module.

Trauma After the Terror: Navigating the Immigrant Experience

(Abstract #196049)

Poster # T-188 (Assess Dx, Cul Div) **Exhibition Hall, 4th Floor**

Technical Level: Intermediate

Underwood, Beverly, MSW[1]**; Antuna, Claudette, MSW, MHSA**[1]

[1]*Argosy University, Bellevue, Washington, USA*

After fleeing terrorism from their home countries, refugees and asylum seekers often face new trauma in the form of detention, deportation without due process, racial profiling, wage theft or forced labor, family separation and limited access to health and education. The first portion of this presentation will address the concerns delineated by a report delivered to the United Nations Human Rights Council on March 5, 2008, addressing the violations of migrant rights. The second portion will speak to the trauma created by trying to navigate the immigration system. There will be a brief discussion regarding the different ways in which undocumented individuals can seek legal remedy to establish status Barret & George, 2005). The third portion of this program will explore the use of psychological assessments and court testimony in assisting this vulnerable population. Culturally and linguistically competent psychological assessments not only

presents the migrant's case, it validates and tells the individual's story of trauma and terror (Mollica, 2004). To facilitate skill building, case studies will be presented in a didactic format to increase the knowledge base of working with this population.

War and the Struggle for Meaning: Exploring the Existential Dilemmas of the Combat Veteran

(Abstract #196050)

Poster # T-189 (Practice,Prev EI) **Exhibition Hall, 4th Floor**

Wills, Sharon, PhD[1]; Hopewell, C. Alan, PhD[2]; Penk, Walter, PhD[3]; Stone, Andrew, MD[4]

[1]Psychology Service, Central Texas Veterans Healthcare System, Austin, Texas, USA
[2]785th Med.Co, Med Psychologist, Major, United States Army, Austin, Texas, USA
[3]Psychology, Central Texas Veterans Healthcare System, Austin, Texas, USA
[4]Psychiatry, Veterans Affairs MedicalCenter, Philadelphia, Pennsylvania, USA

Never before in U.S. history have so many combat veterans been treated in VA mental health clinics while the conflicts they deployed to are still ongoing. The use of evidence based psychotherapies in trauma treatment is an important innovation, but it is vital to expand these psychotherapies to address some of the more common existential dilemmas presented to us by our patients, particularly those issues that are beyond the ordinary realm of PTSD treatment. Death, freedom, isolation, and meaninglessness, the domains of existential psychotherapy as described by Yalom (1980), include key issues encountered in combat experience that may not arise in exposure therapies. Making meaning is a necessary task of treatment. (Frankl, 1959). The sense of loss of meaning can lead to greater utilization of mental health services, suggesting that "greater consideration be given to addressing existential questions in the treatment of PTSD." (Fontana and Rosenheck, 2004). This panel will explore the existential implications of war zone exposure in the current conflicts, such as the struggle to find meaning in experiences that involve death, dying, threat to life and personal integrity, resolving guilt, and finding a means of honoring dead comrades without supporting continued conflict. Existential considerations for the therapist facing this material will also be explored.

Impulsivity and PTSD in a Low-Income, Urban Community Sample

(Abstract #196051)

Poster # T-190 (Clin Res, Cul Div) **Exhibition Hall, 4th Floor**

Russ, Eric, MA[1]; Gapen, Mark, MA[1]; Castleberry, Josh, BA[2]; Crain, Daniel, BA[1]; Bradley, Rebekah, PhD[3]; Ressler, Kerry, PhD[1]

[1]Emory University, Atlanta, Georgia, USA
[2]Psychiatry and Behavioral Sciences, Emory University, Atlanta, Georgia, USA
[3]Emory University, Decatur, Georgia, USA

A number of theoretical models suggest that those individuals with PTSD demonstrate higher levels of impulsivity in thoughts and behaviors. The current study draws from a NIMH-funded study investigating environmental and genetic risk factors for PTSD in a sample of low SES, African American men and women seeking care in the primary care and ob-gyn clinics of a public urban hospital. We are proposing to present data on the relationship between impulsivity on the Barratt Impulsivity Scale (BIS) and PTSD symptoms as measured by the Posttraumatic Stress Scale-Revised from 779 participants in the above described study. Our data indicate the following relationships: 1) impulsivity and trauma exposure ($r = 0.34$, $p < .00$), 2) impulsivity and PTSD symptoms, and 3) impulsivity and other behavioral symptoms such as life time history of problems with alcohol and/or substance use. Of note, the relationships between impulsivity and PTSD is stronger in females ($F = 9.64$, $p < .00$), suggesting that research on the relationship between PTSD and impulsivity needs to take gender into account. We will also use our data to present clinical, public policy, and theoretical implications for understanding and preventing potential negative impacts of trauma in this highly traumatized but under-studied and under-served population.

Knowing What We Know and What We Don't Know About Trauma Treatment

(Abstract #196058)

Poster # T-191 (Media, Practice) **Exhibition Hall, 4th Floor**

Julian, Terri, PhD[1]; Scaturo, Douglas, PhD[2]; McClellan, Michelle, PhD[3]

[1]Veterans Healthcare System-VISN2, Amherst, New York, USA
[2]Syracuse Vet Center, Fayetteville, New York, USA
[3]Veterans Healthcare System, Buffalo, New York, USA

Since 1980, a great amount of literature and research data has informed us about the nature of psychological trauma and its aftermath. and while many professionals are trained in circumscribed areas of treatment and practice, professionals with a sufficient breadth of knowledge in this field are needed to address the diversity and scope of presenting challenges. Given the surge in returning troops from highly volatile combat zones, and the increased knowledge of the effects of military sexual trauma, it is particularly timely to ascertain the skills and knowledge of trauma providers in the field. Given this need, it seems important to have an instrument to assess the base of knowledge needed for clinicians to practice in this area. We have utilized the ISTSS Practice Guidelines (Foa, Keane, & Friedman, 2000) as the knowledge base for items in our self-assessment questionnaire to assess competency for practice in this field. This proposed panel would review the development of this basic trauma knowledge assessment tool, the instrument, and preliminary findings of the instrument administration to clinicians actively practicing in the field today.

Alcohol Frequency, Quantity, and Perceived Effects as Respective Mediators of Sexual Abuse and Risk

(Abstract #196062)

Poster # T-192 (EI, Child) **Exhibition Hall, 4th Floor**

Nugent, Nicole, PhD[1]; Brown, Larry, MD[1]; Houck, Christopher, PhD[1]; Peters, April, MDIV[1]

[1]Brown Medical School, Providence, Rhode Island, USA

Childhood sexual abuse (CSA) has been associated with risky sex behaviors in adolescents (Brown et al., 1997, 2000; Cinq-Mars et al., 2003; Cunningham et al., 1994), including increased reporting of combining sex with alcohol/substance use (Elze et al., 2001). However, no investigations have examined whether alcohol use serves as a mediator between CSA and risky sex in youth. Further, the relative degree to which this relationship may be mediated by frequency of alcohol use, quantity imbibed, or subjective effects of alcohol has not been explored. Path analysis was applied to a sample of 212 youth recruited from area alternative schools to test three separate mediational models with the prediction of number of risky sex acts by CSA mediated by alcohol frequency (defined as number of days drank in past 90 days), quantity (number of drinks per drinking day), and effects (number of drinking days respondent "got buzzed"). Fit indices of respective models supported acceptable to excellent fit indices, with subjective effects of alcohol showing slightly better fit indices: $X2(1)=.01$, $p=.95$, $TLI=1.36$, $CFI=1.00$, $RMSEA=.00$. Implications and limitations of presented data are discussed.

Poster # T-193 (withdrawn)

Fear and Self Schemas in Posttraumatic Stress Disorder

(Abstract #196064)

Poster # T-194 (Res Meth, Assess Dx) **Exhibition Hall, 4th Floor**

Daie-Gabai, Ayala, MA[1]; Foa, Edna, PA[2]; Shafran, Naama, MA[1]; Gilboa-Schechtman, Eva, PhD[3]

[1]Department of Psychology and the Gonda Brain Science Center, Bar Ilan University, Ramat Gan, Israel
[2]University of Pennsylvania, Philadelphia, Pennsylvania, USA
[3]Bar Ilan University, Ramat Gan, Israel

We examined the proposition that trauma alters schemas about world & self using cognitive & self-report measures. In Study 1, fear & self schemas among trauma victims suffering from PTSD (n=19) and those without PTSD (TnoPTSD, n=25) were examined using modified versions of the Implicit Association Test (IAT) & self-reported world and self perceptions. PTSDs exhibited a more dysfunctional fear schema when measured both implicitly and explicitly; and reported lower self-perceptions, but did not exhibit more negative implicit self perception. Study 2 focused on resilience and compared TnoPTSD (n=24) to PTSD participants (n=18) and individuals who were not exposed to trauma (NoT, n=20). Explicit measures of Study 1, self IAT and emotional processing variables were collected. As hypothesized, TnoPTSD participants reported less negative perception of the world; more regulation self efficacy & emotional clarity; and more positive self perception compared to PTSD participants. No difference on implicit measure was found. Contrary to our hypothesis, the TnoPTSD group was not different from the NoT group on any of the self, world or emotional processing scales.

Chronic Stress and Burnout Among Urban Workers

(Abstract #196067)

Poster # T-195 (Commun; Ethics) **Exhibition Hall, 4th Floor**

Tilahun, Bikat, Doctoral Student, MA[1]; Lee, Hanna, Doctoral Student[1]; Love, Sean, Doctoral Student[2]; Chen, Emily, Doctoral Student[1]; Robin, Blair, Doctoral Student[1]; Eriksson, Cynthia B., PhD[2]

[1]Fuller Graduate School of Psychology, Pasadena, California, USA
[2]Graduate School of Psychology, Fuller Theological Seminary, Pasadena, California, USA

A positive relationship between chronic stress and burnout has been documented in expatriate aid workers, but no research has replicated these findings in urban human service workers in the United States. In this study, urban workers were volunteer and paid staff working in intercity neighborhoods in multiple capacities such as education and violence prevention programs. Participants from five metropolitan cities (N = 284) completed surveys to assess chronic stress and its relationship to job burnout (using the Maslach Burnout Inventory; MBI). Chronic stress exposure was also compared between volunteer and paid staff. Findings indicated a positive correlation between chronic stress and the three subscales of the MBI: Emotional Exhaustion, $r = .47$, $p < .01$; Depersonalization, $r = .26$, $p < .01$; and Personal Accomplishment, $r = .20$, $p < .01$. The top five chronic stressors reported were: "feeling powerless to change the situation of the people in the community", "frustration with portrayals of urban life in media", "difficulty finding time for rest and relaxation", "violence in the community" and "encountering subtle racist attitudes". As expected, paid staff reported more chronic stress than volunteer workers, $F(1, 283) = 17.28$, $p < .001$. Practical implications of the unique findings were discussed.

Psychometric Properties of the Hebrew Version of the PTCI Following Single Event Trauma

(Abstract #196068)

Poster # T-196 (Assess Dx, Res Meth) **Exhibition Hall, 4th Floor**

Daie-Gabai, Ayala, MA[1]; Aderka, Idan, MA[1]; Foa, Edna, PA[2]; Shafran, Naama, MA[3]; Gilboa-Schechtman, Eva, PhD[3]

[1]Department of Psychology and the Gonda Brain Science Center, Bar Ilan University, Ramat Gan, Israel
[2]University of Pennsylvania, Philadelphia, Pennsylvania, USA
[3]Bar Ilan University, Ramat Gan, Israel

The Posttraumatic Cognitions Inventory (PTCI) assesses cognitions hypothesized to be associated with poor recovery from trauma and with the maintenance of PTSD. PTCI has been shown to have a three-factor structure: Negative Cognitions About the Self, Negative Cognitions About the World, & Self-Blame. We examined the factor structure of the Hebrew version of the PTCI using confirmatory factor analysis. Participants were 181 Israeli adults following various types of trauma. Results indicated the three-factor model had a moderate fit with the data. All PTCI factors exhibited high internal consistency. The factors reflecting negative thoughts about the self & the world were significantly associated with measures of PTSD severity, depression and general anxiety, but the self-blame factor was not. PTCI as a whole had high convergent validity and was significantly associated with clinical measures of PTSD and depression, and with other psychological measures such as self perception, self criticism, rumination, emotional clarity & emotional regulation. In conclusion, the Hebrew version of the PTCI exhibits good psychometric properties and can contribute to trauma-related research

Poster # T-197(withdrawn)

Principles of Caring for Combat Injured Families and Their Children

(Abstract #196074)

Poster # T-198 (Mil Emer, Child) **Exhibition Hall, 4th Floor**

Cozza, Stephen, MD[1]; With Combat Injured Families, Workgroup on Intervention, PhD[2]; Guimond, Jennifer, PhD[1]; Ursano, Robert, MD[1]

[1]Department of Psychiatry, Uniformed Services University of the Health Sciences, Bethesda, Maryland, USA
[2]Center for the Study of Traumatic Stress, Uniformed Services University of the Health Sciences, Bethesda, Maryland, USA

Combat injury is a life-changing event that impacts a service member and his or her family. Injury to a parent is a major threat to children of all ages and a challenge for even the most resilient of military families. Parental injury disrupts the family system - its routines, cohesion and sense of safety. Combat injury also affects existing patterns of parenting, as both injured and uninjured parents experience their own emotional responses and face the complicated reality of medical treatment and rehabilitation. Often, adults do not know how to speak to children about the injury, or how much and what kind of information to share. Most children will remain healthy in the face of this stress, but some children may sustain life-changing trajectories in their emotional development and/or their interpersonal relationships. The Workgroup on Intervention with Combat Injured Families, Center for the Study of Traumatic Stress, Uniformed Services University developed ten evidence informed principles of care for combat injured families to guide interventions and support healthy growth and recovery. These principles are appropriate for use in military or civilian settings.

Relationship of Guilt and Meaning in Life to Veterans' PTSD Severity

(Abstract #196079)

Poster # T-199 (Mil Emer, Practice) **Exhibition Hall, 4th Floor**

Owens, Gina P., PhD[1]; Steger, Michael F., PhD[2]; Whitesell, Allison, BS[1]; Herrera, Catherine, BS[1]

[1]Psychology, University of Tennessee, Knoxville, Tennessee, USA
[2]Educational and Counseling Psychology, University of Louisville, Louisville, Kentucky, USA

The relationship among PTSD, combat exposure, and depression among combat veterans has been established. No research to date has examined relationships between guilt and presence of meaning in life as they relate to PTSD among this population, the purpose of the current study. Veterans (N=137) completed self-report measures including the Combat Exposure Scale, PCL-Military version, Depression Anxiety Stress Scales, Guilt Inventory, and Meaning in Life Questionnaire. The majority of participants were male (92%), Caucasian (93%), and served in the Vietnam War (78%). A hierarchical linear regression was performed to determine predictors of PTSD severity. Significant predictors were depression, combat exposure, guilt, presence of meaning, and the interaction between depression and meaning in life (F(5,115) = 42.198, Adj. R2 = .64). While controlling for depression and combat exposure, higher levels of guilt and lower levels of meaning were related to higher levels of PTSD severity. The interaction between depression and meaning suggests that at low and moderate levels of depression, higher levels of a sense of meaning are related to lower PTSD severity. Implications regarding the potential protective factor of meaning will be discussed.

The Parent Guidance Assessment – Combat Injured (PGA-CI)

(Abstract #196081)

Poster # T-200 (Mil Emer, Child) **Exhibition Hall, 4th Floor**

Cozza, Stephen, MD[1]; Chun, Ryo Sook, MD[2]; Schneider, Brett, MD[2]; Fullerton, Carol, PhD[1]; Guimond, Jennifer, PhD[1]

[1]Department of Psychiatry, Uniformed Services University of the Health Sciences, Bethesda, Maryland, USA
[2]Department of Psychiatry, Walter Reed Army Medical Center, Washington, District of Columbia, USA

Families of combat injured service members face unique challenges. The Parent Guidance Assessment – Combat Injured (PGA-CI) is a semi-structured clinical interview for collecting preliminary family, child, and parent information from the spouses of recently hospitalized, severely injured service members and for guiding appropriate child and family interventions. The PGA-CI is designed to provide a selective but sufficiently broad summary portrait of the injury-related issues, cascade of events, problems and concerns that affect wounded service member's children, spouses and other family members. A record review of PGA-CI interviews at Walter Reed Army Medical Center was conducted as part of this preliminary investigation. Multiple domains of family experience are described: family demographics and deployment experience, nature of service member combat injury, nature of the family notification of injury, family life events following injury notification, parent-child injury-related communication, injury-related parent and child behavioral and emotional responses and concerns, and planning for future family needs.

Testing the Factorial Equivalencies of the Rumination Items Across a U.S. and Japanese Samples

(Abstract #196082)

Poster # T-201 (Cul Div, Res Meth) **Exhibition Hall, 4th Floor**

Taku, Kanako, PhD[1]; Cann, Arnie, PhD[1]; Calhoun, Lawrence, PhD[1]; Tedeschi, Richard, PhD[1]

[1]Psychology, University of North Carolina at Charlotte, Charlotte, North Carolina, USA

This study assessed the cross-cultural consistency of cognitive processing in the aftermath of a traumatic event in U.S. and Japanese samples, by examining the factor structure of a scale measuring intrusive and deliberate rumination. Participants from the U.S. (N = 224) and Japan (N = 431) rated the degree of rumination occurring soon after their traumatic event and at the survey point. Multiple-group confirmatory factor analyses supported a four-factor model (Intrusive Rumination Soon After and Recently, Deliberate Rumination Soon After and Recently) with cross-loadings held over in both samples, indicating that the factor loadings and variances were invariant across samples. Results also showed that the factor covariances differed significantly across samples, suggesting that the relationships among the factors should be considered as potentially sample-specific. The current results illustrated the importance of considering rumination after traumatic events as multidimensional and as varying across time. Having verified that the factor structure is invariant across these two cultural contexts, the scale can now be used in future studies to assess the bases for possible differences across samples in the relationships among the rumination styles.

Studying the OIF Returnees Post-Deployment Social Situation and Their Mental Health Needs

(Abstract #196083)

Poster # T-202 (Assess Dx, Res Meth) **Exhibition Hall, 4th Floor**

Luchins, Daniel, MD[1]; Weine, Stevan, MD[2]; Basu, Anirban, PhD[3]; Jordan, Neil, PhD[4]

[1]Psychiatry, University of Illinois at Chicago, Chicago, Illinois, USA
[2]University of Illinois at Chicago, Chicago, Illinois, USA
[3]Medicine, University of Chicago, Chicago, Illinois, USA
[4]Psychiatry, Northwestern University, Chicago, Illinois, USA

In OIF returnees(as in the general population) there is a complicated relationship between who screens positive for mental health problems, is referred for care, meets diagnostic criteria for a disorder, perceives a need for treatment, receives treatment and has their needs met. Much attention has been focused on 'barriers' to care seeking by returnees, but there are social and economic factors that act in the opposite direction. for example returnees who are unemployed, divorced/ separated, or have marital or social conflict are more likely to seek care. This is in keeping with historical trends. The Vietnam Veterans Readjustment Study found rates of PTSD were roughly doubled in those who lacked a high school degree, were unemployed, or had a low income with pre-military factors such as coming from a poor family, having childhood behavioral problems, and abuse of substance before entering the military, being strong predictors of subsequently developing PTSD. To understand these relationships the strength and limitations of a proposed, multidisciplinary study using telephone surveys, electronic medical records and ethnographic techniques will be discussed.

Avoidant Coping as a Mediator Between Peritraumatic Dissociation and Posttraumatic Stress Symptoms

(Abstract #196084)

Poster # T-203 (EI, Mil Emer) **Exhibition Hall, 4th Floor**

Pacella, Maria L., BA[1]; Irish, Leah, MA[1]; Sledjeski, Eve, PhD[2]; Fallon, William, MD[3]; Spoonster, Eileen, RN[3]; Delahanty, Doug, PhD[1]

[1]Kent State University, Kent, Ohio, USA
[2]Wesleyan University, Middletown, Connecticut, USA
[3]Summa Health System, Akron, Ohio, USA

According to a recent meta-analysis, peritraumatic dissociation (PD) is one of the strongest predictors of posttraumatic stress disorder (PTSD). However, numerous studies have questioned the predictive utility of PD. Identification of mechanisms through which PD contributes to the development of PTSD would inform theory regarding the predictive utility of PD. Use of avoidant coping strategies (behavioral disengagement, denial, self-distraction) may serve as a behavioral mechanism through which PD leads to maladaptive outcomes. The current study examined the extent to which avoidance coping served as a mechanism through which PD contributed to posttraumatic stress symptoms (PTSS) in a sample of 119 motor vehicle accident victims. The Peritraumatic Dissociative Experience Questionnaire was administered in-hospital and the Brief Cope was administered 6-weeks post-trauma. The CAPS was administered 6 months post-trauma to measure PTSS. Regression analyses revealed that PD and avoidant coping predicted PTSS and that PD predicted avoidance coping after controlling for age and gender (p's < .01). A Sobel test confirmed avoidant coping as a mediator between PD and the development of PTSS ($\Delta\beta$= .120; z = 2.86; p = .004). Interventions targeted at reducing avoidance in those who experience high PD may reduce the likelihood of future PTSS.

Does Cognitive-Behavioral Therapy Change the Brain?

(Abstract #196085)

Poster # T-204 (Clin Res, Bio Med) **Exhibition Hall, 4th Floor**

Porto, Patrícia, MS[1]; Figueira, Ivan, MD[1]; Oliveira, Letícia, PhD[2]; Volchan, Eliane, PhD[1]; Ventura, Paula, PhD[2]

[1]Federal University of Rio de Janeiro, Rio de Janeiro, Brazil
[2]Universidade Federal Fluminense, Niter¢i, Rio de Janeiro, Brazil

This article presents a systematic review of neuroimage in anxiety disorders. Our objective is to investigate neurobiological changes related to cognitive-behavioral therapy (CBT) in anxiety disorders detected through neuroimaging techniques and to identify predictors of response to treatment. We searched Pubmed, Psychoinfo and Web of Science databases from 2006 to 2007. Ten resulting articles met the selection criteria of this review. CBT modified mainly neural circuits involved in the regulation of negative emotions and fear extinction in judged treatment responders. The only study on predictors of response to treatment was regarding obsessive-compulsive disorder and showed higher pre-treatment regional metabolic activity in the left orbitofrontal cortex associated with a better response to behavioral therapy. Despite methodological limitations, initial neuroimaging studies revealed that CBT interventions were able to change dysfunctions of the nervous system related to anxiety disorders in judged treatment responders.

Terror as a Mechanism of Control: The Experience of Victims of Human Trafficking

(Abstract #196086)

Poster # T-205 (Practice, Ethics) **Exhibition Hall, 4th Floor**

Gupta, Sonali, PsyD[1]

[1]Center for Multicultural Human Services, Falls Church, Virginia, USA

Human trafficking involves the recruitment, harboring, transportation, provision or obtaining of a person for the purpose of sexual exploitation or forced labor via the use of force, fraud, or coercion. The trafficked victim is subjected to various forms of abuse the purpose of which is in part to create extreme feelings of fear that support the continued manipulation and exploitation of the individual. Physical, sexual, and psychological abuse, forced use of drugs and alcohol, social restrictions, and high-risk, abusive living and working conditions are some of the methods traffickers use to create a pervasive state of terror. Upon escaping the trafficking situation, the effects of this fear linger and not only continue to exert control over various aspects of the individual's life, but also influence the victim's physical and psychological recovery process and ability to access services, seek restitution, and achieve legal status. This presentation will discuss the use of terror in the trafficking context and the impact on the victim. Clinical interventions that specifically address the fear and its sequellae and thereby support recovery will be described. Lastly, implications for current policies regulating assistance to victims of trafficking will be discussed.

A Proposed Cut-Off Score for the Peritraumatic Distress Inventory

(Abstract #196090)

Poster # T-206 (Assess Dx,Prev EI) **Exhibition Hall, 4th Floor**

Guardia, Dewi, MD[1]; Ducrocq, Francois, MD[2]; Duhamel, Alain, PhD[1]; Demarty, Anne-Laure, PhD[3]; Brunet, Alain, PhD[4]; Vaiva, Guillaume, MD, PhD[2]

[1]University Hospital of Lille, Lille, France
[2]Pole de Psychiatrie et Pole des Urgences, University Hospital of Lille, Lille, France
[3]CIC 9301, University Hospital of Lille, LIille, France
[4]McGill University Douglas Hospital, Verdun, Quebec, Canada

The Peritraumatic Distress Inventory (PDI) is a well recognized assessment tool for post-immediate emotional reactions. Nevertheless, no cut-off score is yet available which would help predict the development of acute or chronic PTSD, or any other trauma-related disorder.

Objective: To define and propose a cut-off score for the PDI.

Method: The study included 205 road traffic accident victims consecutively hospitalized in a Trauma Center. During the 5 days after admission, the PDI was administered. Six weeks and 1 year after the accident, a modified version of the CAPS was administered by phone by an experienced clinical psychologist. One year after the accident, the Mood Depressive Disorders and the Anxiety Disorders sections of the MINI were administered. Statistical analyses were performed using the SAS software (V8.0).

Results: At 6 weeks, 90% of the victims with PDI total score of more than 28 developed acute PTSD at follow up; and 90% of the victims with PDI total score of less than 7 did not develop any trauma related disorders.

Conclusion: We propose a PDI total cutting score of 14 (sensitivity=73% and specificity=60% - Area Under Curve=0,7) and we will test this hypothesis in other populations.

Do Cognitive Factors Predict Posttraumatic Growth (PTG) in Individuals Diagnosed HIV-Positive?

(Abstract #196091)

Poster # T-207 (Bio Med,Prev EI) **Exhibition Hall, 4th Floor**

Nightingale, Vienna, MS[1]; Sher, Tamara, PhD[2]

[1]Institute of Psychology, Illinois Institute of Technology, Bowling Green, Kentucky, USA

[2]Institute of Psychology, Illinois Institute of Technology, Chicago, Illinois, USA

Research on PTG in traumatized populations is flourishing. However, little is known about how PTG occurs. Calhoun and Tedeschi (2007) suggest the event must be seismic in nature for the process of PTG to begin. Further, some cognitive factors including ruminations and assumptions are related to the amount of PTG. What remains unclear is how these cognitive factors might best be measured and thus further understood in their relationship to PTG.

This study examines ruminations (then intrusive, then deliberate, current intrusive, and current deliberate) measured with the Rumination Scale (Calhoun, Cann, Tedeschi, & McMillan, 2000) and world assumptions (benevolence of the world, meaningfulness of the world, and self-worth) measured with the World Assumptions Scale (Janoff-Bulman, 1989) and their relationship to PTG in a convenience sample (n=118) of individuals with HIV.

Two multiple regression analyses, one including assumptions and the other ruminations, were conducted to predict overall PTG. Both regressions were significant. Both assumptions and ruminations offer predictive power. Self-worth and current deliberate ruminations were most strongly related to PTG with correlations of .411, $p < .01$ and .304, $p < .01$. After partialling out the effects of the other variables both were still strongly related to PTG. Results and implications will be discussed.

Doxazosine, an Alpha1-Adrenergic Antagonist, Has Positive Effects on Posttraumatic Stress Disorder

(Abstract #196092)

Poster # T-208 (Clin Res, Bio Med) **Exhibition Hall, 4th Floor**

de Jong, Joop, MD[1]; Wauben, Prudence, MD[1]; Oolders, Hans, MD[1]; Huijbrechts, Irma, PhD[1]; Haffmans, Judith, PhD[1]

[1]ParnassiaBavoGroep, The Hague, The Netherlands, Netherlands

Background: Post traumatic stress disorder (PTSD) is for many a disabling disease. Pharmacotherapy can be helpful and research is on-going. Prazosine, an alpha1-adrenergic antagonist, appeared to reduce night time PTSD symptoms in PTSD, daytime prazosin reduced distress specifically to trauma cues. Adding daytime prazosin to bedtime prazosin reduced overall PTSD symptoms further. Doxazosin, another alpha1-adrenergic antagonist, is prescribed for treatment of hypertension and benign prostate hypertrophy, and available in a slow release form. This allows a once daily dosage, higher initiation dose and less side effects. The hypothesis of doxazosine long-acting is a positive effect on night- and daytime PTSD symptoms and this will reflect on other quality of life.

Objective: The evaluation of Doxazosin long-acting efficacy for sleep disturbances and overall PTSD symptoms.

Method: participants with chronic PTSD receive Doxazosin long-acting in a 12 week open label trial.

Findings: interim preliminary analysis showed an average subject improvement on the Dutch version of the CAPS (clinician administered PTSD scale) scores, as well as the measures for criterion B and D separately. Clinical Global Impression scores improved as well.

Conclusions: Preliminary results show positive effects of Doxazosin long-acting on symptoms in PTSD and warrants further research.

Trauma Symptoms and Suicide Risk in French General Population

(Abstract #196094)

Poster # T-209 (Res Meth, Assess Dx) **Exhibition Hall, 4th Floor**

Jardon, Vincent, MD[1]; Ducrocq, Francois, MD[2]; Jehel, Louis, MD, PhD[3]; Molenda, Sylvie, PhD[1]; Roelandt, Jean-Luc, MD[4]; Vaiva, Guillaume, MD, PhD[1]

[1]Pole de Psychiatrie Pole des Urgences, University Hospital of Lille, Lille, France

[2]University Hospital of Lille, Lille, France

[3]Unite de Psychiatrie et Psychotraumatisme, University Hospital of Paris, Tenon APHP, Paris, France

[4]WHO French Collaborating Center in Mental Health, Armentieres, France

The psychological effects of the exposition to a traumatic event and the suicidal behaviours represent two major concerns in public health. The links between these phenomena, both relative to death, are studied only recently in the international literature. A large epidemiological study was built in France concerning mental health in general population (SMPG) based on a recruitment in 47 metropolitan places between 1999 and 2003. On the basis of MINI were determined the prevalence of the mental disorders, their functional consequences and the different care systems used by the subjects. A second phase allowed an estimation of the suicidal risk in more than 30.000 subjects. The aim of this work was to examine the crossed prevalences of the various levels of suicidal risk with the various registers of psychotrauma. A "marked" suicidal risk was established in 4% of the general population. The distinction of several levels of psychotraumatic suffering lead us to determine a 0.7 % prevalence of full PTSD, to establish the risk to be exposed to a traumatic event to 30 % while finally underlining that 5 % of the population were concerned with this clinical suffering during the last 12 months. Reaffirming the direct links between suicide and trauma, we found a growing gradient between the suicidal risk and the various forms of psychotraumatic symptoms.

Psychological Effects on HIV Disease Progression Following Hurricane Katrina

(Abstract #196095)

Poster # T-210 (Disaster, Practice) **Exhibition Hall, 4th Floor**

Kissinger, Patricia, PhD[1]; Reilly, Kathleen, MPH[1]; Benight, Charles, PhD[2]; Schmidt, Norine, MPH[1]; Curtin, Erin, MPH[1]

[1]Tulane University School of Public Health and Tropical Medicine, New Orleans, Louisiana, USA

[2]University of Colorado at Colorado Springs, Colorado Springs, Colorado, USA

Purpose: In August 2005 Hurricane Katrina displaced approximately 8000 HIV-infected persons. The psychological effects on the disease progression of HIV-infected patients from this disaster is unknown.

Methods: One year post-storm, we interviewed 145 patients who had attended the HIV Outpatient Program clinic prior to the storm. We gathered information on demographics and psychological measures, along with HIV-related laboratory results.

Findings: Fifty-four (37.2%) patients had posttraumatic stress disorder (PTSD) one year after the storm. There was no significant difference in median CD4 before the hurricane for those who had PTSD (285) and those who did not have PTSD (374) ($p=0.46$). There were, however, significantly more CD4 for those with PTSD at one year (247 vs. 357 ($p=0.003$)) and 18 months after the hurricane (283 vs. 383 ($p=0.01$)). Likewise, median log-transformed HIV viral loads were not significantly different pre-storm (PTSD: 8.94, no PTSD: 5.99 ($p=0.13$)), but those with PTSD had higher viral loads both at one year (7.71 vs. 5.99 ($p=0.03$)), and 18 months (6.26 vs.5.99) ($p=0.007$).

Conclusion: Those with HIV that develop PTSD after experiencing a traumatic event are more likely to progress in their HIV severity. Special assistance should be provided to HIV patients at the time of disasters to prevent deleterious psychological events and HIV progression.

Racial Disparities in Trauma Exposure, PTSD, and Service Use Among Female Veterans in Primary Care

(Abstract #196096)

Poster # T-211 (Mil Emer, Cul Div) **Exhibition Hall, 4th Floor**

Grubaugh, Anouk, PhD[1]

[1]*Medical University of South Carolina, Charleston, South Carolina, USA*

Objective: To compare female African American (n =84) and Caucasian (n =99) veterans from primary care clinics at four VAMCs on prevalence rates of trauma, PTSD, other psychiatric diagnoses, functional status, and use of VA services and disability benefits.

Methods: Analyses were based on a cross-sectional, epidemiological design incorporating self-report measures, structured interviews, and chart reviews.

Results: With the exception of higher rates of child sexual abuse among Caucasian women and higher rates of physical assault among African American women, there were no other statistically significant racial differences across analyses. However, some meaningful clinical differences emerged across other variables, and the implications of these findings are discussed within the context of our other results.

Conclusions: African American and Caucasian female veterans do not differ dramatically with regard to the manifestation or severity of psychopathology, or in their use of relevant VA healthcare services and disability benefits. These data are important as women represent the fastest growing segment of the VA population after aging veterans. Further research is needed to replicate and extend these findings to ensure that female veterans' needs are adequately identified and met by VAMC providers.

A Pilot Study of PTSD and Alcohol and Drug Use in Iraq Combat Veterans Recruited From Primary Care

(Abstract #196097)

Poster # T-212 (Mil Emer, Res Meth) **Exhibition Hall, 4th Floor**

Tirone, Vanessa, BA[1]**; Bishop, Todd, MA**[2]**; Ouimette, Paige, PhD**[1]

[1]*Center for Integrated Health Care, Syracuse VA Medical Center, Syracuse, New York, USA*

[2]*Psychology, Syracuse University, Syracuse, New York, USA*

Veterans with combat exposure are at risk for developing Post Traumatic Stress Disorder (PTSD) and substance use disorders (SUD). These veterans are more likely to seek assistance from primary care than specialty mental health settings. This pilot study examines feasibility of recruitment, rates of PTSD and SUD, and associations between PTSD symptoms and alcohol use among Iraq War veterans recruited from primary care. Patients who scored positive for risky drinking and reported Iraq War-related combat exposure completed structured clinical interviews, including the Clinician-Administered PTSD Scale, Time Line Follow Back, and SUD portion of the Structured Clinical Interview for Diagnosis-IV. Sixty-three percent of participants who were contacted and met criteria completed the protocol (n=14). Results indicated that 85.7% (n = 12) met lifetime criteria for an alcohol use disorder, 50% (n = 7) met criteria for lifetime SUD, and 50% (n = 7) met criteria for current PTSD. Past month PTSD symptoms were related to several indices of past month drinking behavior including number of days binge drinking (r = .46). Our results suggest returning veterans will participate in trauma research and PTSD symptoms are associated with risky alcohol use. Primary Care based interventions for SUD and PTSD may be warranted.

Effects of Evacuation on the Well-Being of Hurricane Katrina Survivors

(Abstract #196098)

Poster # T-213 (Disaster, Ethics) **Exhibition Hall, 4th Floor**

LaJoie, A. Scott, PhD[1]**; Sprang, Ginny, PhD**[2]**; McKinney, W. Paul, MD**[3]

[1]*Health Promotion and Behavioral Sciences, University of Louisville, Louisville, Kentucky, USA*

[2]*University of Kentucky, Lexington, Kentucky, USA*

[3]*School of Public Health and Information Sciences, Louisville, Kentucky, USA*

This presentation reports the results of a series of semi structured, hour-long interviews with Hurricane Katrina evacuees. Interviews were done at the first anniversary of the hurricane and involved two samples: people who first evacuated to Louisville, KY and later returned to the Gulf Coast, and, people who evacuated to and stayed in Louisville. Responses were collected from 101 evacuees; the sample was largely African American (65%) and female (62%) with a mean age of 42 years. Measures of psychological distress, including depression, anxiety, and PTSD, and quality of well-being were obtained. Results indicated that depression and anxiety levels were high and that slightly more than 50% of the sample met criteria for PTSD. Psychological distress was significantly higher in those who returned to the Gulf Coast versus those who stayed in Kentucky. Quality of well-being, which reflects the respondents' quality of life, was low overall (mean = .61, SD = .19, where 1 is the quality of life associated with perfect health and 0, death) and did not differ between those who returned or stayed. While quality of well-being was not predicted by other factors, psychological distress was associated with exposure, secondary trauma, gender, and relocation status.

Are Common "Nontraumatic" Events Capable of Eliciting Posttraumatic Stress?

(Abstract #196099)

Poster # T-214 (Practice, Ethics) **Exhibition Hall, 4th Floor**

Robinson, Jordan, BSC[1]**; Larson, Christine, PhD**[2]

[1]*Michigan State University, East Lansing, Michigan, USA*

[2]*University of Wisconsin-Milwaukee, Milwaukee, Wisconsin, USA*

A diagnosis of Posttraumatic Stress Disorder (PTSD) has long been conceptualized as having been preceded by a particularly traumatic stressor (e.g., combat exposure, rape, violent assault, etc). Recent research suggests that more common stressful events (e.g., relational problems, divorce, expected death of a loved one, etc) are also capable of eliciting posttraumatic symptomatology (Mol et al, 2005; Gold et al., 2005; Bodkin et al., 2007). The current study attempted to replicate and strengthen these previous findings by obtaining a large enough sample to examine three groups of event exposure (e.g., those who reported experiencing only traumatic events, those who only reported experiencing significant "non-traumatic" life events, and those who experienced both types of events), whereas previous studies only examined two groups of individuals (those who had a traumatic event and those who did not). The current study confirmed previous findings and found that all three groups of event exposure experienced similar amounts of PTSD symptomatology across symptoms clusters (reexperiencing, avoidance, and hyperarousal). These data add to the growing literature that suggests that the type of events that cause symptoms of PTSD may be broader than the current diagnostic criteria indicate.

Increased Heart Rate Variability Affects Posttraumatic Stress Disorder Symptom Improvement

(Abstract #196100)

Poster # T-215 (Assess Dx, Bio Med) **Exhibition Hall, 4th Floor**

Zucker, Terri, PhD[1]; Samuelson, Kristin, PhD[2]; Gevirtz, Richard, PhD[1]

[1]Alliant International University, San Diego, California, USA
[2]Alliant International University, San Francisco, California, USA

A core, distinguishing feature of posttraumatic stress disorder (PTSD) is heightened psychophysiological activity. Studies have found that heart rate variability (HRV), a biomarker of autonomic functioning, is affected by PTSD. Several intervention studies, assessing psychopharmacology, cognitive behavioral therapy, eye movement desensitization, and hatha yoga, have used HRV as a biomarker for treatment improvement and have shown that an increase in HRV is related to a concurrent reduction in traumatic stress symptoms. This randomized controlled trial compared a respiratory sinus arrhythmia (RSA) biofeedback experimental condition to a progressive muscle relaxation (PMR) control procedure over a 4-week period with 38 persons with elevated PTSD symptoms in residential treatment facility for substance abuse disorder. Primary outcomes included change in HRV amplitude as well as symptoms of PTSD and depression. The most substantial findings were that an increase in HRV predicted PTSD symptom improvement and a statistical trend in depressive symptoms. These results underscore the need for further HRV assessment studies targeting features of heightened psychophysiological activity associated with PTSD.

A New Paradigm for Understanding the Israeli/Palestinian Conflict

(Abstract #196111)

Poster # T-216 (Media, Ed) **Exhibition Hall, 4th Floor**

Ross, Gina, MFT[1]

[1]International Trauma-Healing Institute, Los Angeles, California, USA

Multiple outside traumatic forces that fuel and perpetuate the intractability of the Israeli/Palestinian Conflict may be the missing piece to attain peace. The traumatic impact of terror, violence and war on a nation's psyche, generates traumatic narratives and impaired survival responses that perpetuate trauma and seriously affect a nation's capacity to find creative solutions for problems. Viewing this conflict through the paradigm shift of healing trauma to achieve peace can help address and resolve the many traumatic forces that keep feeding it. Through a compelling visual presentation, this workshop (75m) explores the different world vortices impeding the conflict's resolution and suggests guidelines to approach and resolve this multi-pronged conflict. It also presents a model that addresses the resolution of collective trauma and violence beyond politics, helping adversarial populations build a rational foundation for a healing dialogue. It engages the diverse social sectors that interface with trauma in order to promote the tools that can stabilize the collective nervous system of populations. Addressing the underlying emotional foundation behind the intractability of the Israeli/Palestinian conflict and offering a helpful framework, this workshop is useful for therapists, NGOs, peace workers and mediators, as well as for media personnel and opinion and policy-makers.

An Examination of the Differential Effects of Traumatic Events and Life Stressors

(Abstract #196112)

Poster # T-217 (Assess Dx, Res Meth) **Exhibition Hall, 4th Floor**

Lancaster, Steven L., BA[1]; Melka, Stephen E., BA[1]; Rodriguez, Benjamin F., PhD[1]

[1]Southern Illinois University, Carbondale, Illinois, USA

Recent evidence as suggested that people who have survived traumatic events, as defined in the *DSM-IV* are no more likely to develop symptoms of Posttraumatic Stress Disorder than people who experience other types of events which they deem stressful. The primary goal of the current study was to examine if nature of a stressful event is related to the psychological consequences of that event using improved methodology over previous studies in this area. This was done by comparing participants who self-report having experienced traumatic events to those who report stressful life events but no traumatic events. The results indicated that participants who had experienced a traumatic event had significantly higher scores on a measure of PTSD symptoms ($F(1) = 12.679$, $p < .001$) than those who had not; further, participants who had experienced a traumatic event were more likely to meet diagnostic criteria for PTSD ($2(1) = 4.458$, $p = .035$). Further analyses will examine emotional reactions at the time of the event and how they differ across type of stressful event. It can be concluded that experiencing a traumatic event, as defined in *DSM-IV,* is more likely to lead to symptoms of PTSD than experiencing other types of events.

Prevalence and Sequelae of Betrayal Trauma in a Japanese Student Sample

(Abstract #200461)

Poster # T-218 (Assess Dx, Cul Div) **Exhibition Hall, 4th Floor**

Allard, Carolyn, PhD[1]

[1]University of California, San Diego, and VA San Diego Healthcare System,San Diego, California, USA

Betrayal trauma theory was tested in a convenience sample of 79 Japanese university students. Betrayal trauma theory predicts heightened psychological and memory disturbance associated with abuse perpetrated by someone close (high betrayal trauma) compared to abuse perpetrated by someone not close (medium betrayal) and non-interpersonal trauma (low betrayal). This betrayal trauma effect is theorized to occur due to the conflict that arises in high betrayal situations between the need to maintain attachment to the close other and the withdrawal or confrontation behavior that betrayal usually calls for. In addition endorsement of traditional Japanese cultural values was assessed to test the hypothesis that interdependence-based cultural values would exacerbate the betrayal effect due to increased attachment needs. High betrayal childhood trauma was reported by 47% of the sample and it significantly predicted depressive and posttraumatic stress disorder symptoms above and beyond symptoms related to medium betrayal and non-interpersonal trauma. Memory disruption was more likely for high betrayal but not medium betrayal abuse compared to non-interpersonal traumas. Interdependence-based cultural values did not moderate these betrayal effects. These findings contribute to the limited empirical literature on child abuse in Japan and partially support betrayal trauma theory.

Session 2: Friday, November 14
Exhibition Hall, 4th Floor

Poster Organization

Each poster is scheduled for either Poster Session 1 on Thursday, Poster Session 2 on Friday or Poster Session 3 on Saturday. Each session includes a one-hour time period where the presenting author is available to answer questions.

Posters are organized within the final program by presentation day. The presenting author is underlined. In addition, the index provided at the back of the final program includes all of the authors. A floor map showing the layout of posters is available in the poster hall and on page 160.

Session 2: Friday, November 14
Exhibition Hall, 4th Floor

Poster Set-Up:	7:30 a.m. – 9:30 a.m.
Poster Display:	9:30 a.m. – 6:00 p.m.
Poster Presentation:	5:00 p.m. – 6:00 p.m.
Poster Dismantle:	6:00 p.m.

Poster Dismantle

Immediately following your scheduled poster session, display materials must be taken down and removed. Items not removed by the appointed poster dismantle time **will be disposed** of and are not the responsibility of ISTSS.

Tracks

Posters will be presented on a wide variety of topics indicating track:

1. Assessment/Diagnosis (Assess Dx)
2. Biological/Medical (Bio Med)
3. Children and Adolescents (Child)
4. Civilians in War/Refugees (Civil Ref)
5. Clinical or Interventions Research (Clin Res)
6. Clinical Practice Issues (Practice)
7. Community Programs (Commun)
8. Culture/Diversity (Cul Div)
9. Disaster/Mass Trauma (Disaster)
10. Media/Training/Education (Media Ed)
11. Military/Emergency Services/Aid workers (Mil Emer)
12. Prevention/Early Intervention (Prev EI)
13. Research Methodology (Res Meth)
14. Social Issues/Public Policy/Ethics (Soc Ethic)

Pathways to Cultural Competence: Assessing and Treating Traumatized Latino Children and Families

(Abstract #196113)

Poster # F-101 (Cul Div, Practice) **Exhibition Hall, 4th Floor**

Conradi, Lisa, PsyD[1]; Hendricks, Alison, LCSW[1]; Merino, Clorinda, MED[1]

[1]Chadwick Center for Children and Families, Rady Children's Hospital, San Diego, California, USA

Currently available research on the efficacy of Evidence-Based Treatment (EBT) for traumatized Latino children is scarce. Further resources are needed on how to best adapt Evidence-Based Practices (EBPs) for work with Latino populations. The presenters have created Adaptation Guidelines for the delivery of EBTs/EBPs to Latino families as part of the National Child Traumatic Stress Network (NCTSN). Experts in the fields of child trauma research, clinical practice, policy and cultural competence have participated in multiple focus groups designed to ascertain how evidence-based practices and mental health practice in general can best be adapted to fit the needs of traumatized Latino children and families. The results of this groundbreaking project will be presented along with specific recommendations for individuals and organizations to improve their provision of culturally competent services for Latino families. Attendees will learn concrete ways to support Latino families on both a micro level (conducting a thorough assessment and providing culturally competent therapeutic services) to a macro level (organizational competence, policy changes, and to improve service utilization). This presentation will be appropriate for both mental health providers and program administrators who serve Latino families.

African-American Women and the Terror of Intimate Partner Abuse: Critical Analysis of the Literature

(Abstract #196114)

Poster # F-102 (Cul Div, Clin Res) **Exhibition Hall, 4th Floor**

Tillman, Shaquita, MA[1]

[1]Pepperdine University, Los Angeles, California, USA

The terror of intimate partner violence impacts the lives of women from all racial and socioeconomic backgrounds. However, the intersection of gender, race and socioeconomic status place African-American women at increased risk of experiencing violence from an intimate partner. Statistics have indicated that among African American women between the ages of 15 and 34, homicide by an intimate partner is the leading cause of death. The psychological effects associated with intimate partner violence include depression, anxiety, posttraumatic stress disorder (PTSD) and suicide ideations and actions. The purpose of this literature review is to provide a critique of the current scholarship examining the various coping strategies African-American female survivors of intimate partner violence utilize i.e., informal and formal social support, religion/spirituality, and substance use. The author provides a summary of the literature, gaps in current empirical studies, and needs for future study. Finally research-informed recommendations are provided, including the recommendation for forms of trauma therapy that address ethnocultural and race related variables as they intersect with the recovery process.

The Symptoms of Trauma Scale (SOTS): A Pilot Study

(Abstract #196117)

Poster # F-103 (Assess Dx, Clin Res) **Exhibition Hall, 4th Floor**

Mendelsohn, Michaela, PhD[1]; Kallivayalil, Diya, PhD[1]; Levitan, Jocelyn, BA[1]; Pratts, Michael, MD[2]; Opler, Mark, PhD, MPH[2]; Herman, Judith, MD[1]

[1]Department of Psychiatry, Cambridge Health Alliance, Victims of Violence Program, Somerville, Massachusetts, USA
[2]The PANSS Institute, New York, New York, USA

The Symptoms of Trauma Scale (SOTS) was developed to provide a comprehensive, time-efficient and change-sensitive measure of trauma symptoms that can be used to study treatment outcome. The SOTS is a twelve-item seven-point rating scale assessing severity of symptoms associated with both *DSM-IV* Post Traumatic Stress Disorder and Complex Posttraumatic Stress Disorder. To ensure that information is gathered in a consistent manner, the SOTS package includes a semi-structured clinical interview (the SCI-SOTS) as well as a training curriculum and certification process. This presentation describes a pilot study of the SOTS conducted at the Victims of Violence Program of the Cambridge Health Alliance/Harvard Medical School. Thirty adult patients seeking outpatient individual or group trauma treatment were interviewed using the SCI-SOTS and were rated on the twelve SOTS items by two clinicians. Patients also completed self-report measures of posttraumatic stress, depression, dissociation, self-esteem, interpersonal functioning, affect regulation, and suicidal and self-harming behaviors. Data were analyzed for interrater reliability as well as agreement between scores on the SOTS and other established trauma-related instruments. The findings indicate that the SOTS is a user-friendly measure that is well tolerated by patients and has promising psychometric properties.

Poster # F-104 (withdrawn)

Temperament Stability in Children Exposed to Domestic Violence

(Abstract #196123)

Poster # F-105 (Child, Clin Res) **Exhibition Hall, 4th Floor**

Black, J. Audie, BA[1]; Field, Lia R., BA[1]; Penny, Saleem H., MA[1]; Levendosky, Alytia A., PhD[1]; Bogat, G. Anne, PhD[1]; Von Eye, Alexander, PhD[1]

[1]Department of Psychology, Michigan State University, East Lansing, Michigan, USA

Child temperament is influenced by both genetic and environmental factors, but may be particularly sensitive to unstable or traumatic childrearing environments, such as growing up with domestic violence (DV). Using a longitudinal approach, the present study will examine the effects of DV exposure on child temperament stability from ages 1 to 4. The broad traits of Negative Emotionality (NEM), Positive Emotionality (PEM), and Constraint (CON) (Tellegen, 2003) will be used. We hypothesize that different trajectories of DV exposure will be associated with the following temperament outcomes: 1) non-DV exposed children will display the most constant temperament profile, 2) continuously exposed children will exhibit an unstable temperament profile with linear trajectories (e.g., higher NEM, lower PEM, and lower CON), and 3) children exposed to intermittent DV will demonstrate the most unstable temperament profile, reflecting their inconsistent rearing environment. 184 mother-child dyads participated in this longitudinal study with temperament and DV measured annually. Preliminary analyses support the three-trait temperament structure, as well as codable patterns of DV trajectories across the four time points. This study will advance understanding of temperament in/stability in early childhood in the context of environmental risk factors.

Defense Against Betrayal? Borderline Personality Disorder

(Abstract #196126)

Poster # F-106 (Child, Clin Res) **Exhibition Hall, 4th Floor**

Kaehler, Laura, MS[1]; Freyd, Jennifer, PhD[2]

[1]Psychology, University of Oregon, Eugene, Oregon, USA
[2]University of Oregon, Eugene, Oregon, USA

Borderline Personality Disorder has been associated with both trauma and insecure attachment styles. Betrayal Trauma Theory proposes survivors of interpersonal trauma may remain unaware of betrayal in order to maintain a necessary attachment. This preliminary study reports on the relationship between self-reports of betrayal trauma experiences and borderline personality characteristics in a college sample. As much of the sample were college freshmen (Mage=20.1, SD=3.4), this study directly looks at childhood trauma and its relationship to adolescent personality characteristics. Using multiple regression, betrayal was significantly associated with BPD characteristics. Trauma with high-betrayal was the largest contributor to borderline traits and trauma with medium betrayal was also a significant predictor. However, trauma low in betrayal was not associated with BPD features. These results stand even after controlling for gender. These findings suggest betrayal may be a key, and yet heretofore unaddressed, feature of borderline personality disorder.

From Terrorists to Freedom Fighters (and Back?): Restoring the Dignity of South African Ex-Combatants

(Abstract #200654)

Poster F-107 (Cul Div, Soc Ethic) **Exhibition Hall, 4th Floor**

Bandeira, Monica, MA[1]; Friedman, Merle, MA, PhD[2]

[1]Centre for the Study of Violence and Reconciliation, Johannesburg, Gauteng, South Africa
[2]South African Institute for Traumatic Stress, Saxonwold, South Africa

One of the main areas of concern for countries in the aftermath of terror and the emergence of new democracies is the way in which the perpetrators of terror are reintegrated. In countries where this was poorly managed, these individuals/groups emerge as looming threats to society. This presentation explores: the psychosocial interventions available to South African ex-combatants; their perceived impact; the challenges and obstacles faced by this group; the lessons learned through this work; other interventions required; and the role government should play. Twenty ex-combatants and six organisations were interviewed and qualitative methods of data collection and analysis were used. Although the results reveal interesting differences and similarities between ex-combatants and organisational members, the report concludes that the need for psychosocial interventions aimed specifically at ex-combatants still exists although the manner in which this occurs may need to be re-evaluated. In addition, political will must be fostered and the sector strengthened if the needs of ex-combatants are to be addressed. Interventions aimed at economic empowerment should be developed and recognition plays a central role in the healing of South African ex-combatants. Ex-combatants have a great deal to contribute to society, but if ignored have the potential to threaten democracy.

Psychometric Properties of the Child's Reaction to Traumatic Events Scale-Revised-Chinese Version

(Abstract #196129)

Poster # F-108 (Assess Dx, Cul Div) **Exhibition Hall, 4th Floor**

Chen, Yi-Chuen, PhD[1]; Fortson, Beverly L., PhD[2]; Lai, Yu-Chieh, BS[1]; Lee, Yi-Kung, MD[3]

[1]Department of Psychology, National Chung Cheng University, Taiwan, Chia-Yi, Taiwan
[2]Department of Psychology, University of South Carolina-Aiken, Aiken, South Carolina, USA
[3]Departments of Emergency Medicine and Surgery, Buddhist Dalin Tzu Chi General Hospital, Chia-Yi, Taiwan

Current measures of childhood posttraumatic stress disorder (PTSD) were designed primarily for the assessment of PTSD in native English speaking children. In the current study, the factor structure, internal consistency, and convergent validity of a Chinese version of the Child's Reaction to Traumatic Events Scale-Revised (CRTES-R-C) were examined. The sample consisted of 26 school-aged children who were exposed to a motor vehicle crash (MVC). Factor analyses generally confirmed the three-factor structure (accounting for 19.59%, 16.77%, and 13.58% of the variance, respectively); however, marked discrepancies exist for the items loading on the first two extracted factors as compared to the original English version of the measure. Moderate to high internal consistency was found for the entire scale and the resulting factors (alphas = .79 to .89). Convergent validity was supported by the moderate correlation ($r = .68$, $p < .01$) between the CRTES-R-C total scores and the total number of symptoms assessed by the PTSD section of the Anxiety Disorders Interview Schedule, Child Version. The findings suggest acceptable psychometric properties of the CRTES-R-C. Future studies are needed to further clarify the factor structure of the measure with a larger sample size or among those persons who have experienced different types of trauma.

Chronic Pain & PTSD – New Mechanisms of Comorbidity and First Results of A CBT-Biofeedback Approach

(Abstract #196131)

Poster # F-109 (Clin Res, Civil Ref) **Exhibition Hall, 4th Floor**

Liedl, Alexandra, MA[1]; Knaevelsrud, Christine, PhD[2]; Karl, Anke, PhD[3]; Denke, Claudia, PhD[4]; Mueller, Julia, PhD[5]

[1]University of Dresden; Treatment Center for Torture Victims, Berlin, Germany
[2]Treatment Center for Torture Victims, Berlin, Germany
[3]University of Southampton, Highfield, Southampton, United Kingdom
[4]Department of Anesthesiology and Critical Care Medicine, Charité Virchow-Clinic, Berlin, Germany
[5]University Hospital Zurich, Zurich, Switzerland

Many traumatized individuals suffer from PTSD and chronic pain. Understanding the development, maintenance and interaction of these disorders is of crucial importance for treatment. As background the "Perpetual Avoidance Model" will be introduced that explains the above mentioned mechanisms of PTSD and chronic pain. As only few controlled trials examined the efficacy of interventions addressing both disorders, we analysed the efficacy and feasibility of a newly developed pain-focused short-term cognitive-behavioral biofeedback (CBT-BF) approach that addresses chronic pain in traumatized migrants. for these patients no convincing treatment concepts exist so far. We treated 11 (mean age 36±6 years, 73% female) migrants suffering from comorbid chronic pain and PTSD with CBT-BF. They were assessed before, after and 3-months after the intervention with the MINI, the PDS, pain intensity- and coping-questionnaires. After treatment, we found significant increased cognitive and behavioural coping with pain and reduced heart rate reactivity to the stressful and painful diagnostic condition. Three months follow-up supported the positive findings. The findings of this uncontrolled trial indicate a better pain management after CBT-BF designed to address trauma-related pain. The manual proved to be feasible in this population of extremely traumatized patients.

Coping, Psychopathology, and Ego Development Among Male Survivors of Childhood Sexual Abuse

(Abstract #196134)

Poster # F-110 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Sutherland, R. John, MA[1]; Armsworth, Mary, EDD[2]

[1]Educational Psychology, University of Houston & National Center for PTSD-Honolulu, Hawaii, Houston, Texas, USA
[2]University of Houston, Houston, Texas, USA

Few studies have examined factors that enhance or decrease resilience in men who were sexually abused as children (CSA). Such knowledge could add to efforts in developing risk reduction strategies for this population. The current study consisted of a purposive sample of 103 males (mean age=42.7 yrs) with CSA histories who completed the Brief COPE Scale; (Brief COPE; Carver, 1997), the Brief Patient Health Questionnaire (PHQ; Spitzer et al., 1999) and the Brief Washington University Sentence Completion Test (SCT; Hy & Loevinger, 1996). Two one way ANOVAs were conducted to examine the level of ego development with both the age of the survivor and types of pathology. Results indicated that neither age of the survivor nor the type of pathology was associated with ego development. A one way ANOVA was performed to examine the age of the survivor with coping strategy. Results indicated significant associations between the age of the survivor and type of coping strategy used, $F(1, 96) = 4.23$, $p<.05$. Post-hoc tests indicate that older survivors tend to use more positive coping strategies (humor and religion) to cope with their histories of CSA, $p < .001$. Additional results, implications, limitations, and suggestions for future research will be presented.

The Impact of Systemic Family Therapy on Families Following Trauma

(Abstract #196138)

Poster # F-111 (Clin Res, Res Meth) **Exhibition Hall, 4th Floor**

Coulter, Stephen, BSC, MSW, MSOCSC[1]

[1]Queen's University Belfast, Belfast, Antrim, United Kingdom

The impact of standard treatment (trauma-focused cognitive behavioural therapy) is compared to standard treatment plus systemic family therapy for parents and adolescents referred for trauma treatment in Northern Ireland. Impact is primarily measured in terms of family functioning and individual well-being outcomes: specifically, whether there is a difference in the degree of change in family functioning and individual family members' sense of coherence, self-esteem, state of hope and psychiatric symptomatology. A mixed method approach involving randomised control trial methodology and qualitative data collection is used to investigate the effectiveness of the psychosocial interventions in a 'real world' clinical setting. The challenges of developing and implementing this methodology are presented. An 'intention to treat' based description of the pathways taken by all potential participants in the study are illustrated. Interim results from qualitative aspects of the study regarding participants' views of their therapeutic experience are presented in addition to focus group data on therapists' perceptions of the different approaches.

Engaging Communities to Create Trauma-Aware, Trauma-Informed, Trauma-Educated Child Welfare Systems

(Abstract #196139)

Poster # F-112 (Media, Assess Dx) **Exhibition Hall, 4th Floor**

Vergon, Keren S., PhD[1]; Blacklaw, Cynthia, MS[2]

[1]University of South Florida, Tampa, Florida, USA
[2]Children's Home Society of Florida, Pensacola, Florida, USA

This poster presentation describes the development of trauma-aware, trauma-informed, trauma-educated practices in Northwest Florida through collaboration with stakeholders in state and local child welfare systems. Children's Home Society of Florida and the University of South Florida, is a member of the National Child Traumatic Stress Network. This partnership created the Trauma Recovery Initiative (TRI) Center, whose goals include trauma awareness, trauma education, and trauma information dissemination to child welfare and related systems, and to the community. The TRI center also provides Trauma-Focused Cognitive Behavioral Therapy to youth ages 10-14 either at-risk for or involved in the child welfare system. The TRI Center has worked with state partners to implement universal trauma screening for all youth entering the child welfare system in the area. Ninety assessors were trained to provide universal trauma screening, with about 1000 youth screened yearly. This poster reviews training and implementation activities and identifies additional community groups and organizations for future trauma training efforts, including dependency/child welfare case managers, child protective investigators, community mental health providers, law enforcement officials, educators, health care workers, religious organizations, and United Way-funded organizations.

Children's Alexithymia Measure: Part Three of Pilot Study

(Abstract #196141)

Poster # F-113 (Assess Dx, Child) **Exhibition Hall, 4th Floor**

Kimball Franck, Leslie, PhD[1]; Way, Ineke, PhD[2]; Applegate, Brooks, PhD[3]; Black-Pond, Connie, MA[4]; Hyter, Yvette, PhD[5]

[1]Department of Psychiatry, Virginia Commonwealth University, Richmond, Virginia, USA
[2]School of Social Work, Western Michigan University, Kalamazoo, Michigan, USA
[3]Educational Studies, Western Michigan University, Kalamazoo, Michigan, USA
[4]Southwest Michigan Children's Trauma Assessment Center, Kalamazoo, Michigan, USA
[5]Department of Speech Pathology & Audiology, Western Michigan University, Kalamazoo, Michigan, USA

Alexithymia is a cognitive and affective disturbance that interferes with the processing and verbal expression of feelings. To date, two measures have been developed for use with children (Alexithymia Scale for Children [ASC], Fukunishi et al., 1998; Alexithymia Questionnaire for Children [AQC], Rieffe, Oosterveld, & Terwogt, 2006). The English version of the ASC has not been validated and there are no established norms. The AQC is a self-report measure. The current study represents the final stage of piloting on a new caregiver-report measure, the Children's Alexithymia Measure [CAM], for identifying children with alexithymic characteristics. The CAM was developed by conducting focus groups of foster, biological, and adoptive parents of traumatized children, as well as therapists and caseworkers, and receiving input from therapists and researchers who work with traumatized children. The CAM was administered to approximately 230 caregivers of traumatized children (ages 6 to 17). This poster will present a factor analysis of CAM items, reliability and validity information, comparisons with one other measure, and the final version of the CAM with items empirically derived from factor analysis.

Physical Maltreatment as a Risk Factor for High Levels of Alcohol and Drug Use

(Abstract #196145)

Poster # F-114 (Assess Dx, Res Meth) **Exhibition Hall, 4th Floor**

Rabi, Keren, MA[1]; Anderson, Carl, PhD[2]; Lukas, Scott, PhD[3]; Teicher, Martin, MD, PhD[4]

[1]Developmental Biopsychiatry Research Program, McLean Hospital, Belmont, Massachusetts, USA
[2]Psychiatry / The Brain Imaging Center, Harvard Medical School / McLean Hospital, Belmont, Massachusetts, USA
[3]Psychiatry & Pharmacology / Behavioral Psychopharmacology Research Laboratory and Sleep Research Program, Harvard Medical School / McLean Hospital, Belmont, Massachusetts, USA
[4]Psychiatry / Developmental Biopsychiatry Research Program, Harvard Medical School / McLean Hospital, Belmont, Massachusetts, USA

The Adverse Childhood Experience (ACE) study found a strong dose-dependent relationship between number of ACEs and risk for drug or alcohol abuse. It considered all ACEs to be equally problematic. This study compared the effects of exposure to emotional (EM) versus physical (PM) maltreatment on symptom severity and degree of alcohol or drug use.

Participants included (16M/15F) exposed to harsh corporal punishment or physical abuse (PM group); (17M/41F) exposed to parental verbal abuse and/or witnessing domestic violence (EM group); and (22M/42F) controls with no history of maltreatment or Axis I disorders. Subjects were all young adults (21.9±2.2 years).

Subjects underwent detailed psychiatric and neuropsychological evaluations and imaging studies. Information was obtained on number and type of alcoholic beverages consumed during a drinking session, number of sessions per month, and monthly drug use. Depression, anxiety, somatization and anger-hostility were assessed using Kelner's Symptom Questionnaire.

Young adults exposed to EM had significantly higher symptom scores than healthy controls or PM subjects. However, the PM group consumed 2.5- and 2.7-fold more alcohol than controls or EM subjects ($F[2,141]=4.85$, $p< 0.01$, corrected for gender and family history), and used drugs 6.1- and 7.8-fold more frequently ($p<0.0001$). Hence, form of adversity matters.

Recovery From Terror at the Speed of Light

(Abstract #196150)

Poster # F-115 (Practice, Clin Res) **Exhibition Hall, 4th Floor**

Vazquez, Steven, PhD, LPC, LMFT[1]

[1]Lightwork Associates, Hurst, Texas, USA

By accessing the visual system through photic brain stimulation along with the use of principles of interpersonal neurobiology, new capacities for recovery from terror have been developed. Mutual gaze interaction is the process by which the visual system is used by the mother to regulate the child's affect, brain functions, and physiology. The visual system of the child appears to expand from perception of the mother's face to the entire visual environment as the person matures to adulthood. In adults visual brain stimulation can strongly impact the entire brain-body system as evidenced in conditions like Seasonal Affective Disorder (SAD). Emotional Transformation Therapy™ (ETT™) seizes this principle to precisely regulate affect and physiology along with principles from scientific research in developmental psychology, epigenetics, quantum physics and trauma theory.

Visual photic stimulation initiates impulses whose pathways involve the entire brain. Integral membrane protiens function as receptor antennas that resonate with wavelengths of light which alters protein charges causing the receptor to change shape. This phenomena is used when a specific wavelength of light is used to resonate with emotional states to either amplify, inhibit or advance fixated emotions to completion. Through rapid regulation of emotional flooding and dissociation a new level for providing perceived safety for the client is offered. By catalyzing affect, attachment disorders can be shifted to secure attachments and internal working models can be re-configured to achieve long-term changes.

When affective states can be precisely regulated:

- speechlessness about trauma can be converted into verbalization
- somatic memory can be made explicit and processed to completion
- flashbacks can be eliminated
- cognitive distortions and rumination can be relinquished
- impaired self-perception can be transformed

The use of visual entrainment can elicit the exact brainwave states in which trauma occurred as well as locations of powerful resources for recovery. Through pre and post SPECT scans, empirical evidence regarding brain changes in severely traumatized patients through the use of ETT™ have verified the rapid outcome of this method. Other techniques involve a new form of peripheral eye stimulation, and a process by which the exact focal point for eliciting trauma affect in the client's visual field can be identified and processed by the facilitator using a visual target. These processes often result in unprecedented speed and depth of treatment.

Effects of Trauma on Internet Addiction Through Virtual Interpersonal Relationship Proneness

(Abstract #196151)

Poster # F-116 (Clin Res, Child) **Exhibition Hall, 4th Floor**

Kim, Dongil, PhD[1]; Lee, Euna, MS[1]; Chung, Yeoju, MA[1]; Lee, Juyoung, MA[1]

[1]Dept. of Education, Seoul National University, Seoul, South Korea

The present study was conducted to assess prevalence of Posttraumatic Stress Disorder in the youth population of Internet addiction and to examine the effects of Posttraumatic Stress Disorder on internet addiction mediating Virtual (cyber) Interpersonal Relationship Proneness. The relationship between Internet Addiction and Posttraumatic Stress Disorder was examined in a sample of 3,060 students across nation. Participants were students from middle school to high school and selected by Stratified Random Sampling. From October to November in 2007, they went through the series of the scales including Internet Addiction Proneness Scale and Youth Risk Scale and Posttraumatic Stress Diagnostic Scale (PDS) for assessing PTSD symptoms such as reexperiencing, avoidance/numbness, and increased arousal. Especially, the proposed model was tested with 469 students who were marked above 20% in Posttraumatic Stress Diagnostic Scale (high-risk group) through Structural Equation Modeling. The results of this study were as follows. First, students with high-risk internet addiction also had the PTSD symptoms. Second, the factor of Virtual Interpersonal Relationship Proneness worked as a mediator between internet addiction and PTSD. To sum up, PTSD seemed to increase Virtual Interpersonal Relationship Proneness and also to lead more youth to internet addiction problems.

Trauma Exposure and the Drug Endangered Child

(Abstract #196153)

Poster # F-117 (Child, Practice) **Exhibition Hall, 4th Floor**

Sprang, Ginny, PhD[1]; Staton-Tindall, Michele, PhD[2]; Clark, James, PhD[3]

[1]Center for the Study of Violence Against Children, University of Kentucky, Lexington, Kentucky, USA
[2]Social Work, University Of Kentucky, Lexington, Kentucky, USA
[3]University of Kentucky, Lexington, Kentucky, USA

This presentation describes a study that examined the differences in trauma exposure and the response to traumatic events between drug endangered children and non-drug endangered children involved in the child welfare system. This data represents the experiences of 1127 children randomly selected from a child protective service database and represents 20% of all open cases in one state during 2005-2006. Archival data were analyzed to determine the presence of trauma exposure using *DSM-IV*-TR PTSD Criterion A1, and whether or not the child's response to exposure met PTSD Criterion A2. Results reveal high rates of trauma exposure in the DEC group and indicate that trauma exposure and trauma response did significantly vary across groups. This is one of the only studies to examine the unique characteristics of child welfare involved children living with substance using parents using a trauma framework. Implications for the assessment and treatment of child welfare involved children are drawn.

Needs Assessment on Co-Occuring PTSD and Substance Abuse Treatment in VA

(Abstract #196155)

Poster # F-118 (Practice, Mil Emer) **Exhibition Hall, 4th Floor**

Najavits, Lisa, PhD[1]; Mostoufi, Sheeva, BS[1]; Norman, Sonya, PhD[2]; Kivlahan, Daniel, PhD[3]; Kosten, Thomas, MD[4]

[1]VA Boston Healthcare System, Boston, Massachusetts, USA
[2]San Diego VAMC, San Diego, California, USA
[3]VA Puget Sound Healthcare System, Seattle, Washington, USA
[4]Michael E. DeBakey VA Medical Center, Houston, Texas, USA

This project surveyed 148 VA staff regarding treatment of PTSD and substance abuse (administrators, program leaders, clinicians).We queried program needs; clinical dilemmas; engagement issues; and workforce challenges. Ratings were 0 ("not all") to 4 ("greatly"). Results indicated: (a) the dual diagnosis (PTSD/SUD) was perceived as more difficult to treat (M= 2.79, SD=1.00) than either PTSD (M=2.30, SD= .96) or substance abuse (M=2.26, SD=1.06); (b) a high level of gratification in working with this dual diagnosis (M=3.49, SD=.67); (c) the highest-rated challenges are: clients' self harm (M=3.00, SD=.67), potential for violence (M=2.97, SD=.84), lack of providers who are skilled at working with this dual diagnosis (M = 2.75, SD= 1.06). Areas of gratification, however, were consistently higher than areas of difficulty: e.g., teaching new coping skills (M=3.54, SD=.69). Respondents also endorsed what are currently considered "myths" about treatment of this population: before working on PTSD clients need to reduce substance use (M= 2.91, SD=1.44) or attain abstinence (M= 2.50, SD= 2.00); clients need to commit to abstinence at treatment start (M=2.58, SD=1.06); and clinicians must have a degree in mental health to treat PTSD (M=3.01, SD=.96). Discussion includes systems barriers, and the need for increased attention to new veterans.

Trauma Recovery at the Speed of Light

(Abstract #196160)

Poster # F-119 (Practice, Clin Res) **Exhibition Hall, 4th Floor**

Vazquez, Steven, PhD, LPC, LMFT[1]; Paff, Bart, PhD[2]

[1]Lightwork Associates, Hurst, Texas, USA
[2]Private practice, Seattle, Washington, USA

The combined the use of visual brain stimulation with the use of interpersonal neurobiology principles provides a new synthesis for facilitating rapid trauma recovery. The capacity to reduce emotional flooding within seconds through peripheral eye stimulation provides a new level of perceived safety for clients. Dissociated affect can be rapidly identified and retrieved through a new visual feedback technique. Fixated emotion can be advanced to completion through the use of a visual target within the client's visual field. Through photic entrainment, using a light emitting device, the exact brainwave state in which trauma occurred can be consistently retrieved and processed. Through these processes in conjunction with specific interpersonal responses developed for each attachment disorder, emotions can be precisely regulated and traumatic terror responses can be relinquished. Internal working models can be re configured for long-term change through these approaches.

A case study will show how symptoms of flashbacks, cognitive distortion, insomnia, somatic distress and impaired self-perception were relieved through ETT(tm) within one week. Pre and post SPECT scans provide empirical evidence of the powerful changes in the brain of this severely traumatized person who underwent ETT(tm) after all other methods failed.

Suggestibility of PTSD Symptoms in Response to a Graphic Video: Analog Study of Early Intervention

(Abstract #196161)

Poster # F-120 (EI, Clin Res) **Exhibition Hall, 4th Floor**

Scotti, Joseph R., PhD[1]; Jacoby, Vanessa, BS[1]; Krakow, Elisa, PhD[1]
[1]Department of Psychology, West Virginia University, Morgantown, West Virginia, USA

During potentially traumatic events, such as natural disasters or mass violence, emergency mental health personnel use different forms of early intervention programs, such as CISD, in the psychological debriefing of survivors. Recent research has shown that such interventions may be ineffective, even harmful, to some individuals. Bootzin and Bailey (2005) hypothesize that early interventions may have iatrogenic effects on individuals by suggesting symptoms of PTSD. The present study examines the suggestibility of intrusive PTSD symptoms. forty introductory psychology students watched a graphic autopsy video. The experimental group received instructions that suggested mild intrusive symptoms might occur; the control group did not receive these instructions. Four days later, we asked participants to report intrusive symptoms that occurred over the intervening days. We also conducted a free recall interview and a series of yes/no questions, some of which were misleading. The results to be presented will include the differential report of intrusive symptoms by group and differences in recall of the details of the video. Suggestibility of symptoms will be related to prior trauma, prior stress symptoms (IES), death anxiety, and social desirability. The implications of our findings for conducting early intervention programs will be discussed.

Mentally Ill, Intellectually Disabled Youth in Residential Treatment: Creating a Holding Environment

(Abstract #196163)

Poster # F-121 (Child, Practice) **Exhibition Hall, 4th Floor**

Cimmarusti, Rocco, PhD[1]; Alter, Allison, MSMFT[2]; Davis, Christine, MS[1]; Malm, Christine, MS[1]
[1]Eisenberg Campus, Maryville Academy, Bartlett, Illinois, USA
[2]Saint George Program, Maryville Academy, Des Plaines, Illinois, USA

Residential services to mentally ill, intellectually disabled youth with significant childhood trauma histories presents a number of treatment challenges. Their mental illnesses confound assessment of intellectual disability. Their intellectual disabilities confound forms of therapy like cognitive/behavioral approaches. Clinicians in this setting must be hybrids: able to adapt mental health approaches, able to integrate behavioral approaches, and able to attend to the impact of childhood trauma. Our first task is to make it a safe environment for the youth. This workshop will explore the clinical challenges and opportunities afforded by working with this population. We will consider both components of the milieu program and elements of the relationship between staff and youth that build a holding environment. In addition, we will share our reflections on our clinical work-in-progress as we negotiate these various treatment challenges. We will identify clinical efforts that we currently believe to be working well, as well as those that have failed miserably.

Schlogging Through the Bog: Measuring Posttraumatic Growth and Resilience

(Abstract #196165)

Poster # F-122 (Practice, Assess Dx) **Exhibition Hall, 4th Floor**

Williams, Mary Beth, PhD[1]; Stevens-Guille, Elizabeth, PhD[2]
[1]Trauma Recovery Education & Counseling Center, Warrenton, Virginia, USA
[2]Stress and Trauma Recovery Center, Edmonton, Alberta, Canada

The presentation examines qualitative and quantitative measures of posttraumatic resilience Many trauma survivors search for ways to describe their experiences. The use of "The Bog" is an open-ended, qualitative means for survivors to describe their "stuckness," journey, goals, and lessons learned. Combining a minimum four-session bog protocol with quantitative measures (Davidson Trauma Scale, HCL-45, and Connor Davidson Resilience Scale) as pre measures and the Resilience Scale as a post-measure gives an indication of whether or not this process helps develop posttraumatic growth and positive meaning. Trauma survivors who have completed the exercise bring a variety of experiences to their bogs. The second presentation dealos with a number of immigrants who have experienced war, famine, and dislocation who seem to arrive as fully functioning individuals who settle quickly into the fabric of Canadian life. Their resilience seems unassailable until they are involved in a MVA when they begin to experience PTSD. A discussion of resilience with regard to this sample includes results from the Connor Davidson resilience Scale. The scale wil be administered retroactively and be considered for further investigation.

Symptoms of PTSD Mediate the Relationship Between Trauma History and Physical Health

(Abstract #196166)

Poster # F-123 (Res Meth, Bio Med) **Exhibition Hall, 4th Floor**

Gabert, Crystal, BS[1]; Irish, Leah, MA[1]; Fallon, Jr., William F., MD[2]; Humphrys, Kimberly, RN[2]; Delahanty, Douglas, PhD[1]
[1]Kent State University, Kent, Ohio, USA
[2]Division of Trauma, Summa Health System, Akron, Ohio, USA

Previous reviews have indicated that individuals with a trauma history are more likely to report poor physical health. Symptoms of posttraumatic stress disorder (PTSS), which have long been known to have a relationship with poor health, have been suggested as one mechanism explaining this association. The present study examined this relationship in a sample of 184 motor vehicle accidents victims. Six-weeks post-trauma, participants completed the Traumatic Stress Schedule (TSS) to assess trauma history and the Clinician-Administered PTSD Scale (CAPS). Six-months post-trauma, participants were administered the Short form-36 (SF-36) and the Cohen-Hoberman Inventory of Physical Symptoms (CHIPS). Regression analyses revealed that after controlling for gender, age, and injury severity, trauma history and PTSS significantly predicted both poor perceived general health and poor physical health symptoms and that trauma history significantly predicted PTSS (p's < .01). Sobel tests confirmed that symptoms of PTSD was a significant mediator of the relationship between trauma history and perceived general health (=.336;z=2.69;p<.001) and physical health symptoms (=.391;z=2.73;p<.001). These current findings indicate that researchers should investigate physical health as a multi-dimensional construct and study these relationships within a longitudinal framework.

History of Abuse, Substance Use Problems, and Bipolar Disorder in a County Jail Setting

(Abstract #196167)

Poster # F-124 (Assess Dx, Ethics) **Exhibition Hall, 4th Floor**

Shirley, Edwin, PhD[1]; Stines Doane, Lisa, PhD[2]; Goto, Toyomi, MA[1]; Feeny, Norah, PhD[2]; Debanne, Sara M., PhD[3]; Calabrese, Joseph, MD[1]

[1]Department of Psychiatry, Case Western Reserve University, Cleveland, Ohio, USA

[2]Department of Psychology, Case Western Reserve University, Cleveland, Ohio, USA

[3]Department of Epidemiology and Biostatistics, Case Western Reserve University, Cleveland, Ohio, USA

It is estimated that 6-16% of the U.S. jail and prison population has a serious mental illness, but little is known about the impact of abuse experienced on current mental health status in this population. Further, substance use problems may both increase risk for criminal behavior and exacerbate current mood symptoms. The purpose of the current study was to identify and examine the relationships between abuse, substance use, and mental health disorders in a rural jail-based sample of adults. Inmates at a county jail (n=164) consented to meet with an interviewer who conducted a structured interview including the MINI International Neuropsychiatric Interview (MINI), the alcohol and drug sections of the Structured Clinical Interview for *DSM-IV* (SCID) and the Addiction Severity Index (ASI), which assessed both problems associated with substance use and lifetime history of physical, sexual, or emotional abuse (N=72). A logistic regression was conducted to determine whether abuse and problems associated with substance use predicted Bipolar Disorder diagnosis (BP). Preliminary results suggest that a history of any type of abuse and low, moderate, and high levels of substance-related problems based on ASI total score were significant predictors of BP of whom 70% had never been diagnosed.

PTSD, Comorbid Major Depression, and the Cortisol Waking Response in Victims of Domestic Violence

(Abstract #196169)

Poster # F-125 (Bio Med, Assess Dx) **Exhibition Hall, 4th Floor**

Pinna, Keri, MA[1]; Johnson, Dawn, PhD[2]; Delahanty, Doug, PhD[1]

[1]Psychology, Kent State University, Kent, Ohio, USA

[2]Summa Kent State Center for the Treatment and Study of Traumatic Stress, Akron, Ohio, USA

Abnormalities in HPA activity are often noted in both PTSD and Major Depressive Disorder (MDD). Although high rates of comorbidity between the two disorders have been noted, opposite findings in the direction of HPA alterations have been reported. A recent report found comorbid MDD to impact HPA response to the DEX/CRH test, such that HPA reactivity was lower in those with comorbid MDD (de Kloet et la., 2008). The present study sought to extend these findings by examining the relationship between PTSD, MDD and the cortisol waking response in victims of Domestic Violence (N = 64). Results were examined with respect to Area Under the Curve with respect to ground (AUCg: a measure of total cortisol output), and AUC with respect to increase (AUCi: believed to reflect sensitivity to stimulation). While both AUCg and AUCi were similar between PTSD (N = 51) and non-PTSD women (N = 13; ps > .19), AUCi was greater in the Comorbid group (N = 34) compared to the PTSD only group [N = 17; t(48.43) = -2.58, p = .01]. Results support the impact of comorbid MDD on the relationship between PTSD and HPA activity. Examination of the impact of comorbidity may help to clarify the physiological sequelae of trauma, may contribute to our understanding of recovery from trauma, and may be help to guide intervention efforts.

Clinical and Organizational Predictors of Burnout and Traumatic Stress in Emergency Managers

(Abstract #196170)

Poster # F-126 (Disaster, Assess Dx) **Exhibition Hall, 4th Floor**

Monroe, J. Richard, MA[1]; Jacobs, Gerard, PhD[2]

[1]University of South Dakota, Vermillion, South Dakota, USA

[2]Psychology, University of South Dakota & Disaster Mental Health Institute, Vermillion, South Dakota, USA

Burnout has been described as a psychological response characterized by emotional exhaustion, depersonalization, and a reduced feeling of accomplishment during professional situations. Secondary traumatic stress (STS) symptoms include intrusive thoughts, feelings of shock, avoidance, sadness, fatigue, and sleeping problems for professionals working in environments where they have come into contact with traumatized individuals. Professionals working in emergency-specific contexts may be at risk for the effects of burnout and STS due to their close interactions with affected populations and emotionally intense working environments. At the national level, professionals in emergency management and disaster response have indicated low levels of job satisfaction. It is possible that similar levels of job dissatisfaction also exist in emergency management professionals at state and local levels. Empirical research is necessary to identify risk factors associated with increased vulnerability for burnout and STS within the context of emergency management. Using moderated multiple regression analyses, the authors hypothesize that a series of variables including Trait Anger, Type A Behavior Pattern, Role Conflict/Ambiguity, and a Personal Trauma History will differentially moderate the levels of burnout and traumatic stress symptoms in emergency management professionals.

College Student Academic Performance: Coping and Exercise as Mediators of Multiple Sources of Stress

(Abstract #196171)

Poster # F-127 (Assess Dx, Clin Res) **Exhibition Hall, 4th Floor**

Scotti, Joseph R., PhD[1]; Joseph, Brittany, BS[1]; Haines, Christa, BA[1]; Lanham, Courtney, BA[1]; Jacoby, Vanessa, BS[1]

[1]Department of Psychology, West Virginia University, Morgantown, West Virginia, USA

We conducted this study to evaluate the multiple sources of stress (personal, academic, traumatic) experienced by college students, the ways in which they cope with those stressors, and outcome in terms of psychiatric symptoms and academic performance. Approximately 400 introductory psychology students participated for extra credit through an on-line survey website. The participants were primarily freshmen, but represented freshmen through seniors, and were primarily Caucasian (as reflects the student body of the university). We utilized separate published scales to evaluate academic, personal, and traumatic stressors. The Ways of Coping Scale was the primary measure of coping skills; we also measured level of physical activity, exercise, and time management. Our outcome measures included overall and current grade point average, psychological symptoms (Brief Symptom Inventory), and measures of risky behavior (alcohol/substance use, unprotected sex). We will present the primary analyses with regard to the impact of different categories of stressors (individually and combined) on academic performance, as mediated by coping skills, exercise, and time management. Secondary analyses will include the impact on psychological symptoms and their relation to academic performance. The results have implications for student retention and the provision of psychological services.

Multiple Sources of Stress, Risky Behavior, and Psychological Outcome by Sexual Orientation

(Abstract #196173)

Poster # F-128 (Cul Div, Clin Res) **Exhibition Hall, 4th Floor**

Scotti, Joseph R., PhD[1]; Lanham, Courtney, BA[1]; Joseph, Brittany, BS[1]; Haines, Christa, BA[1]; Jacoby, Vanessa, BS[1]

[1]Department of Psychology, West Virginia University, Morgantown, West Virginia, USA

We conducted this study to determine if sexual orientation was associated with different types and levels of stress, and if it was a predictor of risky behaviors and psychological outcomes. Prior studies have focused on sexual orientation itself as a key stressor, and have not included a full range of other life stressors. Over 400 introductory psychology students (55% female; 90% heterosexual; 96% Caucasian) participated in the study via an on-line survey. The participants ranged from freshmen to seniors, but most were freshmen. We evaluated academic, personal (including sexual orientation and other individual characteristics), and traumatic stressors. Our outcome measures included psychological symptoms (Brief Symptom Inventory) and measures of risky behavior (alcohol/substance use, tobacco use, unprotected sex). Our primary analysis will be the relation between sexual orientation and different levels and types of stressors. The secondary analyses include mediators and moderators of the impact of these variables on psychological symptoms and engaging in risky behaviors. The findings provide one of the few analyses of multiple sources of stress and outcomes in relation to sexual orientation. The implications for student counseling and prevention programs will be discussed.

Resistance and Vulnerability to Trauma

(Abstract #196174)

Poster # F-129 (Mil Emer, Res Meth) **Exhibition Hall, 4th Floor**

Morante Benadero, Maria Eugenia, PhD[1]; Moreno-JiméNez, Bernardo, PhD[1]; Garrosa Hernández, Eva, PhD[1]; Rodríguez Munoñz, Alfredo, PhD[1]

[1]Universidad Autónoma de Madrid, Madrid, Spain

Catastrophes affect people who face it directly. In addition, helping others also has a great risk. The purpose of this study was to examine the role of several personality variables (empathy, comprehensibility, challenge and sense of humour) as moderators of the relationship of job demands (traumatic task and overload) with secondary traumatic stress. 175 emergency professionals of the Community of Madrid completed the Secondary Traumatic Stress Measure (STSM).

The results of the hierarchical multiple regression analysis provide evidence for the moderator role of personality variables in the secondary traumatic stress process. Lastly, the discussion emphasises the need to focus on the interaction between personality and job demand variables in order to advance our understanding of the process of trauma in emergency professionals.

Relations Between Cognitive Distortions and Trauma Symptomology Following Sexual Assault

(Abstract #196175)

Poster # F-130 (Clin Res, Assess Dx) **Exhibition Hall, 4th Floor**

White, Elizabeth, BSC, BA[1]; Petretic, Patricia, PhD[1]; Makin-Byrd, Lori, BA, MA[1]; Limberg, Neal, BA, MA[1]; Addison-Brown, Kristin, BA, MA[1]; Jacobs, Ingrid, BA, MA[1]

[1]Department of Psychology, University of Arkansas, Fayetteville, Arkansas, USA

Research has established a relation between sexual assault victimization and a characteristic pattern of trauma symptoms. Relations between interpersonal violence victimization and specific cognitive distortions have also been found. However, research investigating the relation between specific cognitive distortions and characteristic trauma symptoms is limited.

Participants were taken from a study examining the long term impact of trauma. They completed self-report measures of symptomatic distress (TSI), cognitive distortions (CDS), and history of sexual experiences (M-SES). The current study examines a subset of participants (N= 47) who reported sexual assault after age 14, taken from the overall sample of 600 college students.

Regression analyses indicate a correspondence between specific cognitive distortions and characteristic trauma symptoms. Perceptions of helplessness predicted a cluster of symptoms in rape victims, including depression, anxious arousal, anger irritability, intrusive experiences and dissociation, and impaired self-reference when preoccupation with danger was elevated. Preoccupation with danger also predicted dysfunctional sexual behavior and tension-reducing behaviors. Self-blame predicted defensive avoidance and sexual concerns. Assessment of cognitive distortions is recommended to better target the symptoms associated with sexual assault.

Physiological and Psycometric Responses as Indexes of CBT Efficacy in PTSD: A Single-Case Study

(Abstract #196176)

Poster # F-131 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Norte, Carlos, BS[1]; Souza, Gabriela, PhD[1]; Pedrozo, Ana Lúcia, BS[1]; Macedo, Tania, BS[1]; Eliane, Volchan, PhD[1]; Ventura, Paula, PhD[1]

[1]Federal University of Rio de Janeiro, Rio de Janeiro, Brazil

Posttraumatic stress disorder (PTSD) has been associated with dysregulation of the neuroendocrine and autonomic system. Our aim was to investigate the effects of Cognitive Behavioral Therapy (CBT) on the physiological (Heart Rate, Cardiac Vagal Tonus, Skin Conductance) and neuroendocrine (Cortisol and Dehydroepiandrosterone (DHEA)) variables and psychometric self-report measures (negative affect, resilience, PTSD symptoms, depression, anxiety and social support). The patient was a 45-year-old man who had suffered three assaults and failed to respond adequately to pharmacological treatment with selective serotonin reuptake inhibitors. His physiological and psychometric responses at rest were measured before and after four months of CBT. CBT led to reduction of heart rate, skin conductance, and cortisol as well as increase of cardiac vagal tone and DHEA. Furthermore, CBT promoted reduction of PTSD symptoms, depression, anxiety and negative affect scores and enhancement of resilience and social support scores. These results suggest that the dysregulation of neuroendocrine and autonomic system at rest may have been normalized after successful CBT. In the future, these physiological indexes could be used together with self-reported measures to predict and monitor response to CBT.

Marines With Co-Occurring PTSD and Substance Abuse

(Abstract #196181)

Poster # F-132 (Assess Dx, Practice) **Exhibition Hall, 4th Floor**

Najavits, Lisa, PhD[1]

[1]*VA Boston Healthcare System, Boston, Massachusetts, USA*

Self-report measures were administered to 1847 active duty US Marine Corp recruits (826 female; 1021 male) at entry to Parris Island boot camp. Surveys assessed trauma exposure, psychological symptoms and functioning at enlistment. Participants were categorized based on PTSD symptoms and problems with alcohol: those with self-reported PTSD and alcohol problems (n= 48); those with PTSD but not alcohol problems (n=113); those with alcohol problems only (n=219); and those who did not report problems with alcohol or PTSD (n= 1115). Dependent variables were psychopathology, military service, and general life history. Results indicated that the dual diagnosis group was more impaired than all other groups. Overall, of 59 significant outcomes, 30 variables evidenced marines with PTSD and alcohol problems to be were more impaired than those with just alcohol problems, and those with no alcohol or PTSD problems. Those with PTSD only were more impaired than those with alcohol only group and those with no alcohol or PTSD problems, on 42 variables. Those with alcohol problems only, were more impaired on 29 variables compared to those with no alcohol or PTSD problems. Discussion addresses clinical implications, preventive efforts in military settings, and methodology limitations of this project.

Stigmatization of Male and Female Iraq War Veterans With PTSD, Depression, or Chronic Back Pain

(Abstract #196183)

Poster # F-133 (Practice, Mil Emer) **Exhibition Hall, 4th Floor**

Daoud, Melissa, BA[1]**; Prins, Annabel, PhD**[2]**; Kuhn, Eric, PhD**[3]**; Asuncion, Arlene, PhD**[3]**; Rogers, Ronald, PhD**[2]

[1]*Psychology, San Jose State University, Santa Clara, California, USA*
[2]*Psychology, San Jose State University, San Jose, California, USA*
[3]*San Jose State University, San Jose, California, USA*

Background: Stigmatization has been identified as a barrier to care for veterans with mental health problems. Variables that impact stigmatization, such as the specific mental health condition and gender of the veteran, have not been systematically studied. Objective: In this analog study, we examined the degree of stigmatization ascribed to male and female Iraq War veterans diagnosed with PTSD as compared to those diagnosed with depression and chronic back pain. Because research has found that females are less likely to find psychiatric illness stigmatizing, we included gender of the participant in our analyses.

Methods: We randomly assigned 203 undergraduates to read one of 6 clinical vignettes. Each vignette was standardized to include exposure to trauma as well as frequency and duration of symptoms. Stigmatization was measured using the Social Distance Scale.

Results: There was a significant interaction between gender of the participant and diagnosis regardless of the veteran's gender in the vignette: females assigned greater social distance when the diagnosis of depression was depicted and males assigned greater social distance when the diagnosis of PTSD was depicted.

Conclusion: These findings suggest that males and females in the general population view PTSD and depression in Iraq War veterans differently.

Healing Trauma and Combating Hatred With Palestinian Educators

(Abstract #196184)

Poster # F-134 (Child, Prev EI) **Exhibition Hall, 4th Floor**

Ross, Gina, MFT[1]

[1]*International Trauma-Healing Institute, Los Angeles, California, USA*

Biological disturbances resulting from the trauma of terror and violence leave long-term impact on the national collective psyche, furthering violence and perpetuating existing conflicts. Collective trauma distorts group narratives, promoting hatred and dehumanizing discourse. A collective sense of injustice fuels hatred and points to revenge as the only solution. Children reared in collective traumatic narratives, reinforced by media, parents and school curricula, are particularly vulnerable. Working with early childhood educators to fight hatred can reverse the impact of societal trauma and foster peace. In 2007, the West Bank-based Center for Applied Research in Education in Palestine and the Los Angeles non-profit International Trauma-Healing Institute partnered to help Israelis and Palestinians work toward reconciliation. The joint CARE-ITI Palestinian Educators' Program helps teachers identify and curtail the negative effects of trauma in Palestinian society by teaching them how to heal themselves and their students. The trainings provide these educators - who may be unwittingly transferring their own negative feelings to students - unaware of trauma's impact on their own emotions and thoughts, with tools to heal their personal traumas and help their students reverse hatred.

Examining Ego-Resiliency, Posttraumatic Stress Symptoms, and Life Satisfaction in College Students

(Abstract #196185)

Poster # F-135 (Practice,Prev EI) **Exhibition Hall, 4th Floor**

Sebourn, Brandi, BA[1]**; Tiegreen, Sara, MS**[1]**; Smith, River, MA**[1]**; Newman, Elana, PhD**[1]

[1]*University of Tulsa, Tulsa, Oklahoma, USA*

People with higher ego-resiliency may exhibit high adaptability under stress and experience less fear and rumination after a traumatic event than those with lower ego-resiliency (Block & Kremen, 1996). As part of an on-going, larger study on risk and resilience among college students, preliminary analyses examined ego-resiliency (Ego-Resiliency Scale) in relation to post traumatic stress symptoms (PTSD Checklist- Civilian Version) and quality of life (Life Satisfaction Scale). Among the first 47 trauma-exposed college students, students with very high trait ego-resiliency report significantly less post traumatic stress symptoms than those with high trait ego-resiliency ($t(46)=2.70$, $p=.01$). The magnitude of the difference between mean scores was large (eta =.14). In addition, ego-resiliency was positively correlated with quality of life, with high levels of ego-resiliency associated with high levels of satisfaction with life ($r=.28$). Preliminary results suggest that ego-resiliency is associated with a lower degree of post traumatic stress experienced after a traumatic event. Results are tentative and will be updated with larger data set.

PTSD Insomnia Group Revisited: One-Year Follow-Up

(Abstract #196189)

Poster # F-136 (Mil Emer, Clin Res) **Exhibition Hall, 4th Floor**

Roberts, Mary (Kitty), PhD[1]

[1]*Psychology, Department of Veterans Affairs, Salt Lake City, Utah, USA*

Sleep disturbances are common complaints of veterans with PTSD. Some authors believe that the hyperarousal aspects of PTSD may be a core cause of sleep disruption (Woodward, 1995). Nightmare activity has been reported in approximately 70% of veterans with PTSD (Ohayon & Shapiro, 2000). Imagery rehearsal has been used in a group format to reduce the frequency and intensity of

nightmare activity (forbes, Phelps & McHugh, 2001). Scant research has been done examining long-term efficacy of Insomnia group work in PTSD populations. The purpose of this study was to determine efficacy of Insomnia group work after a one-year period with three booster sessions. Approximately 35 veterans with PTSD were followed for a one-year period after completing an initial Insomnia Group consisting of 10 weekly sessions. They participated in three booster sessions and completed The Fear of Sleep Inventory, Insomnia Severity Index, and Sleep Hygiene Inventory after the booster sessions. Data analysis will inform indications for long-term follow-up regarding insomnia group therapy for veterans with PTSD as a result of combat or military sexual trauma.

Treatment Effect of Insomnia Group for Veterans

(Abstract #196190)

Poster # F-137 (Mil Emer, Clin Res) **Exhibition Hall, 4th Floor**

Roberts, Mary (Kitty), PhD[1]

[1]*Psychology, Department of Veterans Affairs, Salt Lake City, Utah, USA*

Sleep disturbances are common complaints of veterans with PTSD. Some authors believe that the hyperarousal aspects of PTSD may be a core cause of sleep disruption (Woodward, 1995). Nightmare activity has been reported in approximately 70% of veterans with PTSD (Ohayon & Shapiro, 2000). The purpose of this study was to examine treatment effects of group therapy for insomnia vs. a self-study control group. Approximately 30 veterans with PTSD participated in group therapy for insomnia with another 30 veterans participating in the independent self-study group. Vets in both groups filled out The Fear of Sleep Inventory, Insomnia Severity Index, and Sleep Hygiene Inventory pre and post-treatment. Weekly group therapy was conducted over a period of ten weeks. The three first sessions covering techniques for reducing severity and/or frequency of nightmares and the last seven sessions covered CBT techniques for insomnia. The self-study group was instructed to read and utilize the sessions included in a notebook on the same weekly schedule as the insomnia group did. Data analysis will compare efficacy of group therapy to self-study for the treatment of insomnia in veterans with PTSD as a result of combat or military sexual trauma.

Empirical Field Research in Post-Genocide Rwanda: Guidelines on Surveying Traumatized Societies

(Abstract #196193)

Poster # F-138 (Civil Ref, Cul Div) **Exhibition Hall, 4th Floor**

Tobias, Jutta, MA[1]

[1]*Washington State University, Washington, District of Columbia, USA*

Rwanda represents a special case for trauma researchers; the ethno-political conflict in this central African nation has been ongoing for decades, and took an extreme shape in the form of a genocide that occurred just over a decade ago. Two obvious consequences of this pose a two-fold challenge for researchers, i.e. a national population that is much younger than it should be, with dramatically high likelihood of having experienced violence and trauma. The purpose of this paper is to detail the consequences of this for psychology field research, and attempts to provide some guidance for researchers considering research with post-conflict populations. A systematic analysis and comparison of two recent field studies with rural Rwandan populations will be provided, detailing challenges and workable solutions on topics such as culture-specific questions liable to re-ignite trauma with research participants, translating survey instruments linguistically and appropriately for a particular public policy environment, and the delicate balance needed for investigating traumatic experience within culturally diverse groups alien to the researcher. Respecting culture, history and politics is essential for conducting field research in post-conflict societies, so as to obtain scientifically valid results and to safeguard the physical and mental health of vulnerable populations.

Gender Differences in Prevalence of IPV, Injury, and Fear in a Randomized Community Sample

(Abstract #196194)

Poster # F-139 (Clin Res,Prev EI) **Exhibition Hall, 4th Floor**

Lary, Heidi, MPH[1]**; O'Leary, K. Daniel, PhD**[1]**; O'Leary, Susan, PhD**[2]

[1]*Psychology Department, State University of New York at Stony Brook, Stony Brook, New York, USA*

[2]*State University of New York at Stony Brook, Stony Brook, New York, USA*

Scholars have posited that the foundation of IPV rests on husbands' desire to maintain power and control over their wives. However, there is converging evidence across studies that the rate of physical aggression against a partner is higher for women than men (Archer, 2000). The present study sought to investigate the evidence behind these seemingly disparate perspectives. Participants included 453 couples who all self-reported frequency of abuse victimization via the Conflict Tactics Scale. Participants reported on amount of fear of partner for specific psychological and physical aggressing behaviors. Results indicated no significant gender differences for prevalence of physical abuse victimization overall or for prevalence of injury overall. Severe injury rates were higher for women than men. Further, when asked in what circumstances they would be afraid of their partner, there was a significant difference across all physically violent behaviors, with females reporting more fear. The strong gender difference in fear levels support the perspective that violence perpetration at the hands of women does differ in qualitative ways from that perpetrated by men. Irrespective of women's higher rates of aggression, women are more fearful of their partners both in specific situations and overall.

Poster # F-140 (withdrawn)

Terror of IPV in the East Asian American Communities

(Abstract #196197)

Poster # F-141 (Cul Div, Clin Res) **Exhibition Hall, 4th Floor**

Chung, Heewoon, MEd[1]

[1]*Pepperdine University, Montrose, California, USA*

Underutilizing mental health services is a prevalent phenomenon among ethnic minorities (Futa 2001; Bryant- Davis 2005). With the added factor of East Asian Americans' tendency to underreport domestic abuse, abused Asian American women often suffer the terror of Intimate Partner Violence in silence. Researchers have attributed this to the group mentality typical of some East Asian cultures, which results in victims sacrificing personal needs in order to maintain harmony in the family (Uba, 1994). Despite underreporting, there are several cultural reasons why East Asian American women carry a higher risk for domestic violence. Structural familial factors put the daughter in the lowest rank within the Asian family hierarchy; furthermore, patriarchal aspects of Asian culture result in the normalization of male dominance. These factors support the fact that Asian American women are likely to experience higher rates of abuse than what research generally reports (Hall, Windover, & Maramba, 1998). Studies that represent the reality of domestic abuse in Asian American communities are crucial. A comparative analysis of IPV in the East Asian immigrant community with East Asians living their own countries, followed by an exploration of possible reasons for the prevalence discrepancies, will shed light on the reality of Asian American family dynamics.

Self-Defeating Personality Disorder or Self-Protective Behavior?: Redemtion of a Flawed Construct

(Abstract #196198)

Poster # F-142 (Practice, Assess Dx) **Exhibition Hall, 4th Floor**

Gold, Steve, PhD[1]; Courtois, Christine, PhD[2]

[1]Center for Psychological Studies, Nova Southeastern University, Fort Lauderdale, Florida, USA

[2]Independent Practice, Washington, District of Columbia, USA

Intense controversy was aroused by the proposed introduction of a new Axis II diagnosis into the *DSM-III*-R: self-defeating personality disorder (SDPD). The criteria comprising SDPD included avoidance of accomplishments, interpersonal support and pleasure, and actively seeking out negative outcomes and maltreatment. Trauma specialists and feminist psychologists rightly argued against the legitimacy of SDPD, framing it as an instance of "blaming the victim."

Rejection of SDPD and its exclusion from subsequent editions of the *DSM* obscured the clinical utility of identifying this constellation of behaviors, which can be understood as understandable self-protective reactions engendered by repeated traumatization. When understood in this way, identification of this behavior pattern can be a useful tool for trauma therapists.

This poster will explain why survivors of complex traumatization often become intensely fearful when things go well in their lives. Intervention strategies for productively managing these potentially disruptive behaviors will be delineated. Case examples illustrating the self-protective function of seemingly "self-defeating" behavior and interventions that can help complex trauma survivors learn to tolerate and eventually welcome positive elements in their lives will be presented.

An Investigation of Methamphetamine Use in Traumatic Event-Exposed Adults With and Without PTSD

(Abstract #196199)

Poster # F-143 (Practice, Bio Med) **Exhibition Hall, 4th Floor**

Smith, Rose, MA[1]; Grooms, Amy, BA[1]; Bown, Stevie, BA[1]; Babson, Kimberly, MA[1]; Feldner, Matthew T., PhD[1]

[1]University of Arkansas, Fayetteville, Arkansas, USA

Relatively little research has examined methamphetamine use as it pertains to posttraumatic stress disorder (PTSD). This paucity of research is noteworthy as methamphetamine use is an increasing public health concern. The aims of the proposed study were to (1) compare lifetime histories of methamphetamine use between traumatic event-exposed adults with, versus without, PTSD, and (2) compare the annual use rates between groups. It was hypothesized that persons with PTSD would more frequently endorse lifetime methamphetamine use. Furthermore, it was hypothesized that individuals with PTSD would report higher annual rates of use. Results suggested that individuals with PTSD, compared to individuals without PTSD, were more likely to report positive lifetime methamphetamine use histories (54.34% versus 22.80%, respectively $X2 = 10.87$, $p < .01$). In addition, statistically nonsignificant trends regarding annual use rates were in the expected direction, with people with PTSD reporting approximately 5.56 uses per year as compared to 1.12 uses per year among traumatic event-exposed adults without PTSD [$F (1, 97) = 3.29$, $p = .07$]. These findings bolster research suggesting substance use is very common among people with PTSD and that thorough assessment of substance use among these individuals is critical for researchers and clinicians working with this population.

Poster # F-144 (withdrawn)

Verbal Memory Deficits in Children With Posttraumatic Stress Disorder

(Abstract #196201)

Poster # F-145 (Child, Assess Dx) **Exhibition Hall, 4th Floor**

Lau, Karen, BA[1]; Hoffman, Casey, PhD[1]; Burnett, Christiane, MA[1]; Samuelson, Kristin, PhD[1]

[1]Alliant International University, San Francisco, California, USA

Studies have shown verbal memory impairments in adults with posttraumatic stress disorder (PTSD); however, these findings have rarely been replicated in studies of children. The few studies examining neuropsychological functioning in children with PTSD have primarily demonstrated impairments in executive function when compared to children without trauma histories, making it unclear whether deficits are related to trauma exposure or to PTSD. We examined verbal memory and learning using the California Verbal Learning Test for Children in 45 children who had witnessed intimate partner violence; 22 children were diagnosed as PTSD+ and 23 were PTSD-, as measured by the CAPS-CA. Groups were matched on age, gender, ethnicity, and IQ. PTSD+ children showed poorer performance on word list recall and learning in comparison to the PTSD- children ($t = 2.37$, $p = 0.022$). This study extends childhood PTSD research by utilizing a comparison group with similar trauma histories, leading to greater certainty that observed deficits are due to PTSD and not trauma exposure. While some researchers have theorized that trauma at different stages of development has different effects on the hippocampus and memory functioning, these results suggest that childhood PTSD may follow a similar pattern of neuropsychological impairment as adult PTSD.

Why Experience Matters: Motivation, Preparedness and Readiness of Disaster Mental Health Responders

(Abstract #196202)

Poster # F-146 (Disaster, Mil Emer) **Exhibition Hall, 4th Floor**

Wiedeman, Rachel, BA[1]; Davis, Joanne, PhD[1]; Ford, Julian, PhD[2]; Elhai, Jon, PhD[3]

[1]University of Tulsa, Tulsa, Oklahoma, USA

[2]Dept of Psychology, University of Connecticut Health Center, Farmington, Connecticut, USA

[3]Psychology Dept, University of South Dakota, Vermillion, South Dakota, USA

This investigation was exploratory in nature and examined the relationship between prior Disaster Mental Health (DMH) deployments and motivation to participate in future DMH responses, and perceived preparedness and readiness for future DMH responses. Participants included 256 individuals employed in the mental or physical health fields who were members of a disaster response team or received disaster response training in Connecticut, New Hampshire or Oklahoma. Based on previous research, the following hypotheses were formed: 1) participants who had previous DMH deployments would have higher perceived preparedness, readiness and motivation for future DMH deployments, 2) previous DMH deployments that involved direct contact with victims/survivors would be related to lower motivation for future deployments in comparison with those who had previous DMH deployments not involving direct contact with victims. Hypothesis 1 was supported in that participants who had previous DMH deployment experiences had significantly higher perceived preparedness and readiness for future deployments than those without previous DMH deployments. Hypothesis 2 received partial support in that direct contact with survivors during a previous deployment was negatively associated with three of the five motivational factors. The strengths, limitations and important implications will be discussed.

Comparative Symptomatology of Youth Reporting Interpersonal vs. Other Trauma in an Urban Community

(Abstract #196212)

Poster # F-147 (Child, Cul Div) **Exhibition Hall, 4th Floor**

Sperry, Debbie M., MA[1]; Stephan, Sharon H., PhD[2]
[1]Southern Illinois University, Carbondale, Illinois, USA
[2]University of Maryland School of Medicine, Baltimore, Maryland, USA

Trauma exposure is common in youth, with highest rates (70-85%) among urban youth. Exposure may produce PTSD, internalizing, externalizing, and risk taking problems.

DSM-IV-TR suggests that interpersonal trauma (IT) is most harmful. Youth are the most common victims of IT. Few studies compare IT vs.other trauma (OT) effects in youth.

This study is designed to compare functioning and identify targets for differential intervention among urban adolescents reporting IT vs.OT.

Students from 8th-9th grades in two urban middle schools were screened with the UCLA-PTSD Index. Highest scorers completed the Strengths and Difficulties Questionnaire and a treatment study. IT was defined as an experience involving traumatic interaction between people, NOT a natural disaster or accident.

Among 161 students, 95 reported IT as most troubling; 61 reported OT as such (5 missing data). No significant differences emerged on demographic or trauma variables. The most common IT was hearing of a friend/relative being shot/beaten/killed; most common OT was death/illness/injury of friend/family.

The OT group unexpectedly reported higher levels of Hyperarousal and Hyperactivity/Inattention. No other differences emerged.

OT may be more deleterious among urban youth. Levels of attachment trauma in the OT group may have impacted findings. Follow-up is needed.

Relationship Between Reflexivity-Impulsivity and Dissociation Among Traumatized People

(Abstract #196221)

Poster # F-148 (Res Meth, Assess Dx) **Exhibition Hall, 4th Floor**

Agarkov, Vsevolod, PhD[1]
[1]Laboratory for Traumatic Stress Studies, Russian Academy of Sciences, Moscow, Russia

It was suggested that among traumatized people cognitive style possesses features of polarization and rigidity. Subjects (n=98, female 38, male 59) were classified into 4 groups: non-traumatized adolescents (n=37) and adults (n=10), traumatized adolescents (n=19) and adults (n=32). All participants were administered LEQ-2 (Ermakov, Kiseleva, Agarkov, 2001) and Russian versions of Dissociation Experience Scale (Agarkov, Tarabrina, Lasko, 1997), IOES-R (Tarabrina, Agarkov, et. al., 2001), Kagan's test for assessing reflexivity impulsivity cognitive style. The analysis of the Kagan test indexes across groups indicate prevalence of impulsive subjects among traumatized adolescents and equal distribution of impulsive and reflexive subjects among traumatized adults. Traumatized groups are distinguished by prevalence of slow/inexact subjects in comparison with non-traumatized groups. Significant Spearmen coefficients of correlations between Kagan test parameters and DES score were obtained only for traumatized groups: (-0.45, $p<0.005$) between Mistakes and DES score among adults; (-0.65, $p<0,05$) between Time and DES score among adolescents.

Turning Trauma Into Resilience: Model & Intervention Based on Action Structure and Mirror Neurons

(Abstract #196229)

Poster # F-149 (Clin Res,Prev EI) **Exhibition Hall, 4th Floor**

Kent, Martha, PhD[1]
[1]Veterans Affairs Medical Center, Phoenix, Arizona, USA

Mirror neurons respond when a monkey or human performs or observes specific motor action. They encode the basic social structure of Agent-action-Object (A-a-O). In trauma this interaction structure is altered from the individual as agent to recipient/object of someone else's action (O-a-A). The agentic self becomes a fragmented self with disturbed episodic memory, procedural memory, alexithymia, lost narratives. This deeper structural change is expressed in the dimension approach/engagement versus withdrawal/defense of the ANS, HPA axis, amygdala, cortisol responses. Our intervention restores agency and approach/engagement resilient response to threat. A twelve-week modularized program calls for childhood re-experiencing of proactive orientation, re-experiencing social relatedness, then uses restored strengths to return to past traumatic experiences to heal suffering and restore homeostasis. It ends with the question, "What is a good life." Pre-testing and post-testing assess effectiveness at three levels: physiological measures of salivary cortisol and heart rate variability, psychological measures of clinical symptoms and positive adjustment, and neuropsychological measures of attention, working memory, and complex reasoning, in randomized treatment and no-treatment control groups. Positive changes were obtained in all three domains in prior pilot studies.

Intellectual Resources and Posttraumatic Stress Disorder in an Urban Primary Care Sample

(Abstract #196230)

Poster # F-150 (Assess Dx, Ethics) **Exhibition Hall, 4th Floor**

Fani, Negar, MS[1]; Ortigo, Kile, MA[2]; Johnson, Eboni, BS[2]; McClure Tone, Erin, PhD[1]; Ressler, Kerry, MD, PhD[2]; Bradley, Rebekah, PhD[2]
[1]Georgia State University, Atlanta, Georgia, USA
[2]Emory University, Atlanta, Georgia, USA

Previous studies have shown an inverse relationship between intellectual abilities and Posttraumatic Stress Disorder (PTSD), suggesting that intelligence may buffer the effects of psychological trauma. Earlier studies have not examined how PTSD status may be associated with differential performance among various subtests of intellectual function. This study observed the relationship between IQ subtests and PTSD in an urban primary care sample.Participants were recruited from primary care clinics as part of a NIH-funded study conducted at an inner-city hospital serving a low-SES population. Participants (N=330) were administered four subtests measuring verbal and nonverbal intellectual ability from the Reynolds Intellectual Assessment Scale.PTSD status did not significantly predict performance on any of the four subtests, even after statistically controlling for education. However, educational level significantly predicted variance in performance among three subtests ($p<.05$). Education and household income also significantly predicted variance in PTSD symptoms ($p<.05$). The majority of this sample received a 12th grade education or less and made less than $1000/month.These data indicate that the relationship between IQ and PTSD in this sample may be complicated by environmental factors, including income and education; implications for future research are presented.

Guidelines for the Development of Permanent Memorials in the Aftermath of Trauma and Terror

(Abstract #196231)

Poster # F-151 (Commun, Ethics) **Exhibition Hall, 4th Floor**

Demaria, Thomas, PhD[1]; Barrett, Minna, PhD[2]; Gurwitch, Robin, PhD[3]; Schonfeld, David, MD[4]; Bray, Grady, PhD[5]

[1]Psychology, Long Island University - C.W. Post, Brookville, New York, USA

[2]Psychology, State University of New York at Old Wetsbury, Oceanside, New York, USA

[3]Department of Pediatrics, University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma, USA

[4]Division of Developmental and Behavioral Pediatrics, Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, USA

[5]Bray Associates, Huntsville, Texas, USA

Memorials are developed to commemorates the lives lost during a tragedy, courage of those that responded and resilience of the community. Memorials also provide a social space for spiritual, emotional, social and psychological healing and reflect an embodiment of hope that lessons learned will help prevent future terrorism.

The Oklahoma City National Memorial and Museum: From Tragedy to Hope

The bombing of the Alfred P. Murrah Federal Building in Oklahoma City on April 19, 1995, remains the largest act of domestic terrorism in the United States. This terrorist action forever changed how the United States and the world looked at the safety and security of the country. In the aftermath of this unprecedented tragedy, the question of how best to memorialize the event was asked. A memorial design was chosen that incorporated the telling of the event and honored the all touched by it. To further memorialize the event, a museum was planned. With committees comprised of those directly impacted by the bombing (family members, survivors, and responders), subject matter experts in a variety of fields and community leaders, the museum was brought to reality. It not only compliments the memorial, but extends its vision. The message of the memorial can be summarized by words contained therein: We come here to remember those who were killed, those who survived and those changed forever. May all who leave here know the impact of violence. May this memorial offer comfort, strength, peace, hope and serenity. This presentation will discuss the memorial and museum development and the sustainability of its message.

Considerations regarding commemoration and memorialization involving school communities This presenatation will draw on twenty years of experience consulting to school systems dealing with crisis events to highlight considerations regarding effective commemoration and memorialization in school settings. Permanent memorials present an opportunity for members of the school community to take an active role in constructing an enduring memory of a crisis event, allowing participants to select both what and how they wish to remember and honor what was lost. for students to benefit from the establishment of permanent memorials, mechanisms to involve them actively in the planning process need to be developed. Schools may find it difficult to respect and incorporate the individual preferences and concerns of students and staff, especially when traumatic reactions lead many within the community to avoid thinking or talking about the events. Examples will be drawn from his work with New York City Public Schools in planning for the 1st and 2nd anniversary of the events of September 11th, as well as other school crisis events, and the implications these hold for the development of permanent memorials.

Memorials Honoring the Loss of Life From Terrorism

Commemoration through the creation of permanent memorials/museums allows for the retelling of historical events, reflecting on the human costs and honoring those who were murdered/victimized by terrorism in any of its forms. It appears to be a necessary step in psychological recovery of victims, those who identify with them and those who recognize the injustice and impacts of the violence. What do Whitwell, TN, Washington, D.C., Yad Vashem in Israel and The Jewish Temple/Museum in Prague, Check Republic have in common? All house memorial museums to the Holocaust. This presentation will discuss the psychological functions of permanent memorials: to resolve incomplete mourning; bear witness to unspeakable evil; recognize remarkable heroism; bring meaning to loss and suffering; and, finally, to draw in new generations of viewers/learners. The presenter, a trauma psychologist who has worked with groups of child survivors of the Holocaust and hundreds of first responders in the aftermath of rescue and recovery following terrorist attacks will discuss the importance of understanding these restorative functions, for those working with survivors/witnesses of terrorism.

Psychological Challenges of Leadership in the Development of Memorials Following Traumatic Events

Leadership is often challenged in the aftermath of traumatic events by the complications of planning time-sensitive rescue and recovery interventions and coordinating efforts to mitigate the impact of the tragedy. This is soon supplanted by efforts to rebuild and restore a community. An essential component that is often considered is whether the traumatic event should be formally maintained in the consciousness of the community. Permanent memorials can indeed serve many different purposes for the community and individuals. Based on lessons learned following acts of terrorism (Oklahoma City Bombing, 9/11 attacks on the World Trade Center) major natural disasters (Boxing Day Tsunami in Thailand, Hurricane Katrina) and numerous air disasters, this presentation will present guidelines that community leadership should consider before permanent structures are developed.

Poster # F-152 (withdrawn) **Exhibition Hall, 4th Floor**

Validity and Confiability of the Brazilian Version of the Clinician Administered PTSD Scale – CAPS

(Abstract #196233)

Poster # F-153 (Assess Dx, Res Meth) **Exhibition Hall, 4th Floor**

Pupo, Mariana, MSc[1]; Jorge, Miguel, PhD[1]; Mello, Marcelo, PhD[1]; Bressan, Rodrigo, PhD[2]; Mari, Jair, PhD[3]

[1]Psychiatry, Federal University at Sao Paulo, Sao Paulo, Brazil

[2]Federal University at Sao Paulo, Sao Paulo, Brazil

[3]Department of Psychiatry and Medical Psychology of the Sao Paulo Medical School (EPM), Universidade Federal de Sao Paulo (UNIFESP), Sao Paulo, Brazil

Epidemiological studies indicated that PTSD is becoming an ever-increasing health problem in global terms. In Brazil, in spite of the high index of urban violence, we still do not have available research tools to diagnose PTSD. Objective: To determine the psychometric characteristics of the CAPS Brazilian version. Methodology: This study is a case-control which included 50 patients diagnosed with PTSD according to the *DSM-IV* criteria and 48 controls subjects. The subjects were both gender, between 18 and 60 years old, from the outpatient clinic of the Program of Victims of Violence of the Federal University of Sao Paulo, Brazil. The CAPS reliability was studied by the interrater method. The concurrent validity was evaluated by comparing the results of the CAPS in relation to the SCID-I and the discriminating validity relating CAPS to the Beck inventories on anxiety and depression. Results: Interrater agreement on the CAPS items, calculated by means of Kappa coefficient, varied from 0,63 to 1. The internal consistency for all core symptoms of CAPS resulted in Cronbach's alfa of 0,97. The area under the ROC curve for PTSD was 0,97, and using a cut-off point of 60 the validity coefficients were as follows: sensitivity 98% and specificity 82%. The CAPS scores correlated positively with Beck scale for depression and anxiety.

Proof-of-Concept Study of Adjunctive Pregnenolone in PTSD

(Abstract #196237)

Poster # F-154 (Clin Res, Bio Med) **Exhibition Hall, 4th Floor**

Payne, Victoria, MD, MS[1]; Naylor, Jennifer, PhD[2]; Hamer, Robert, PhD[3]; Davidson, Jonathan, MD[2]; Strauss, Jennifer, PhD[1]; Marx, Christine, MD, MA[1]

[1]Psychiatry, Duke University Medical Center & Durham VA Medical Center, Durham, North Carolina, USA
[2]Psychiatry, Duke University Medical Center, Durham, North Carolina, USA
[3]University of North Carolina at Chapel Hill, Chapel Hill, North Carolina, USA

Background: Pregnenolone (PR) is a neurosteroid with characteristics relevant to depression, resilience, and anxiety. PR is reduced in depression and its administration increases allopregnanolone (AL), a neuroprotective and anxiolytic metabolite. AL is reduced in females with PTSD. We thus conducted a randomized controlled pilot study of adjunctive PR in PTSD.

Methods: Veterans meeting criteria for PTSD by CAPS were randomized to adjunctive PR or placebo (PBO) for 8 weeks following a 2-week single-blind PBO lead-in. The Beck Depression Inventory-II (BDI) and Connor-Davidson Resilience Scale (RISC) were also administered. Of 20 patients randomized, 17 completed at least 4 weeks of the study. Both LOCF and completer analyses were conducted in this proof-of-concept trial.

Results: Patients randomized to PR did not show significantly greater reductions in CAPS scores compared to the PBO group in either analysis. for the LOCF analyses, effect sizes (ES) for BDI and RISC improvement comparing PR to PBO were 0.09 and 0.32, respectively. for completer analyses, ES for the BDI and RISC were 0.36 and 0.48, respectively, in the predicted direction, and not inconsequential.

Conclusions: Effect sizes for BDI and RISC improvement following adjunctive PR in this pilot study are potentially encouraging and merit future efforts. PR may represent a novel intervention in PTSD.

Resting Heart Rate and Right Frontal Lobe Functioning in Trauma Survivors

(Abstract #196239)

Poster # F-155 (Bio Med, Assess Dx) **Exhibition Hall, 4th Floor**

Immel, Christopher, BA[1]; Hadder, James, BS[2]; Knepp, Michael, MS[2]; Stephens, Chad, MS[2]; Noguchi, Ryoichi, MS[2]; Harrison, David, PhD[2]

[1]Psychology, Virginia Polytechnic Institute and State University, Blacksburg, Virginia, USA
[2]Virginia Polytechnic Institute and State University, Blacksburg, Virginia, USA

Trauma has been shown to have an adverse impact on both mental and physical health outcomes, especially Posttraumatic Stress Disorder (PTSD) and resting heart rate. Though this relationship has been widely studied, the causal mechanism of the relationship between PTSD and heart rate is less well-known. Through use of a preexisting dataset, the current project examines the impact of right frontal lobe functioning on resting heart rate in a group of participants with self-reported high PTSD symptomology (the majority of which resulted from the April 16th, 2007, Virginia Tech Shootings). Results of the project indicate that those with high levels of PTSD symptomology (as recorded by the Impact of Events Scale-Revised) and a low error ratio (tested by the Right Frontal Figural Fluency Task [RUFF]) had significantly lower resting heart rates than those with a high error ratio, $F(36) = 6.34$, $p < .05$. Results further clarify the factors which influence resting heart rate in those with PTSD symptoms, and illustrate the importance of heightened right frontal lobe function in reducing the negative impact of PTSD on physiological outcomes.

Traumatic Experiences and Dissociative Symptoms Among Turkish Young Adult Men

(Abstract #196240)

Poster # F-156 (Disaster, Cul Div) **Exhibition Hall, 4th Floor**

Doruk, Ali, MD[1]; Erdem, Murat, MD[2]; Ozenc, Salim, MD[3]; Uzun, Ozcan, MD[1]

[1]Psychiatry, Gulhane Military Medical Faculty, Ankara, Turkey
[2]Psychiatry, Military Dispensary, Ankara, Turkey
[3]Gulhane Military Medical Faculty, Ankara, Turkey

Objective: The aim of this study was to investigate the profile of trauma and its related to dissociative symptoms among Turkish young men.

Methods: Normative men sample (N=187) were examined with the Trauma History Questionnaire (THQ) and Dissociative Experience Scale (DES).

Results: The mean age was 16.39Ò0.95 years (range 20-35 years). The mean score of DES was 21.6Ò18.2 (0-81). Of the 187 participating subjects, 127 (67.9%) reported total 520 different types traumatic experiences. 30 (16.0%) had only one traumatic experince, 97 (51.9%) reported more than one trauma. Of THQ subgroups, general disaster and trauma were 62.0% (N=116), crime related events were 21.9% (N=41), physical and sexuel experiences were 21.4% (N=40) and other events were 7.0% (N=13). The most frequent experiences were exposure to someone seriously injured or killed (35.8% N=67), serious accident at work, in a car or somewhere else (24.6% N=46), natural disaster (24.6% N=46) and exposure to dead bodies (other than at a funeral) (22.5%, N=42), respectively. The association between traumatic experiences and DES was not found significantly.

Conclusions: Traumatic experiences seem to be rather common among young adult men. Specific meanings attached to traumatic events by different people may be important on the development of dissociation.

Changing Perceptions on the Impact of Trauma: A Qualitative Study of Cognitive Processing Therapy

(Abstract #196241)

Poster # F-157 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Price, Jennifer L., PhD[1]; Adair, Kathryn C., BA[2]; MacDonald, Helen Z., PhD[3]; Monson, Candice M., PhD[2]

[1]Department of Psychology, Georgetown College, Georgetown, Kentucky, USA
[2]Women's Health Sciences Division, National Center for PTSD, Boston, Massachusetts, USA
[3]VA Boston Healthcare System, Boston, Massachusetts, USA

Recent research demonstrates the efficacy of cognitive processing therapy in treating posttraumatic stress disorder in veterans. In addition, research on linguistic analysis suggests that aspects about personality and psychological state can be discerned from an individual's use of language. To date, no research has examined the effect of CPT on change in individuals' use of language over time. The current study aims to evaluate psychotherapy outcome through linguistic analysis of the impact statements written by participants (n=15) prior to and following 12 weeks of cognitive processing therapy for military-related PTSD. The sample included veterans who were predominantly male (87%) with a mean age of 53, most of whom served in the Vietnam War (80%). Using the Linguistic Inquiry and Word Count (LIWC; Pennebaker, Booth, & Francis, 2007) program, preliminary effect size analyses revealed moderate to large changes from session 2 to session 12 impact statements on use of words related to insight (Hedge's g=.69) and positive emotion (Hedge's g=.40). In order to address the limitations of quantitative linguistic analysis, qualitative analysis of the written narratives will also be presented. Implications for future treatment outcome studies will be discussed.

Partnerships That Work: Applications of Trauma-Focused Interventions for Children and Adolescents

(Abstract #196242)

Poster # F-158 (Child, Clin Res) **Exhibition Hall, 4th Floor**

Habib, Mandy, PsyD[1]; Schneider, Alison, LSW[4]; Van Horn, Patricia, JD, PhD[2]; Hastings, Jane, MPA[3]; Knoverek, Angel, MS, LCPC[5]; Kisel, Cassandra, PhD[7]; DeRosa, Ruth, PhD[6]

[1]Adolescent Trauma Treatment Development Center, North Shore University Hospital, Manhasset, New York, USA
[2]University of California San Francisco, San Francisco, California, USA
[3]Illinois Department of Children and Family Services, Chicago, Illinois, USA
[4]Department of Psychiatry and Behavioral Sciences, Northwestern University, Chicago, Illinois, USA
[5]Chaddock, Quincy, Illinois, USA
[6]North Shore University Hospital, Manhasset, New York, USA
[7]Northwestern University Feinberg School of Medicine, Chicago, Illinois, USA

Chronic trauma during childhood has been associated with serious psychological and behavioral consequences. In 2006, the Illinois Department of Children and Family Services (IDCFS) led an Evidence-Based Practices pilot evaluating three trauma-focused interventions. Child-Parent Psychotherapy (CPP), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) were implemented with young children, school-aged children, and adolescents, respectively. This poster will briefly outline key components of two of the interventions (SPARCS and CPP) and will describe the application and evaluation of these treatments across multiple systems levels. Implementation successes and challenges will be highlighted on both state and local levels, and will include the perspective of a youth consumer. Results of the evaluation will be presented on the system-level (e.g. feasibility) and child-level (e.g. symptom reduction, placement stability) and will include strategies for fostering sustainability.

The Effects of Children on Trauma Severity in Women Experiencing Intimate Partner Violence

(Abstract #196243)

Poster # F-159 (Child, Prev EI) **Exhibition Hall, 4th Floor**

Armstrong, Geniel, MA[1]; Bryant, Cody, BA[2]; Fiore, Christine, PhD[1]

[1]Clinical Psychology, University of Montana, Missoula, Montana, USA
[2]Psychology, University of Montana, Missoula, Montana, USA

Violence against women by men in the form of Intimate Partner Violence (IPV) is far too common. The lifetime prevalence of women experiencing IPV by male partners is estimated to be 10-69% (World Health Organization, 2002). Such violence often leads to trauma related symptoms and mental health disorders including Major Depressive Disorder, PTSD, and other anxiety disorders (Coker, 2002). Economic strain, societal pressure, and personal investment in the relationship may make leaving a violent partner more difficult. The decision to stay or leave a violent relationship is further complicated when women have to consider their children's needs. Through quantitative and qualitative analysis this study explores the severity of trauma symptoms in a community sample of 393 women who have experienced IPV. The trauma symptoms and the severity of trauma in women without children and with children are compared. Greater understanding of severity, symptoms and felt experience will be addressed with responses obtained from a semi-structured interview, the Trauma Symptom Checklist, and Conflict Tactics Scale which were completed by the participants. Findings will help service providers and resources better aid women with children who are attempting to end the violence in their lives.

Poster # F-160 (withdrawn) **Exhibition Hall, 4th Floor**

Pre-Deployment Psychological Briefing Methodology: A Sense of Coherence Model

(Abstract #196246)

Poster # F-161 (Res Meth, Clin Res) **Exhibition Hall, 4th Floor**

Levy, Patricia, PhD[1]; Bustos, Rudolph, PhD[2]

[1]Social Work and Sociology, Fort Hays State University, Hays, Kansas, USA
[2]College of Health Sciences, TUI University, Cypress, California, USA

Current pre-deployment mental health preparation models address the psychological aspects of war, however, in a heuristic fashion. Personnel tasked to be deployed in the Middle East will be facing traumatic situations unlike those in American daily life. Decisions to shoot civilians posing real threats, having to gather mutilated bodies or to secure dwellings may require combatants to suspend their feelings. Suppression of emotion can lead to internalized acute and traumatic stress disorders, including vicarious traumatization (compassion fatigue). Empirical stress and health studies support a Sense of Coherence model utilizing a categorical framework focusing on adaptation and of self-affirmation. This model if initiated at Pre-Deployment briefing and carried through at Deployment and at Post-Deployment briefings will reveal not only a chronology in the adjustment process from onset to current functioning, but also will disclose a psychological reconfiguration of self-identity and a meaningful life philosophy.

Emotional Dysregulation and PTSD Symptoms Among College Students

(Abstract #196249)

Poster # F-162 (Clin Res, Assess Dx) **Exhibition Hall, 4th Floor**

Voorhees, Summer, BA[1]; Pennington, Hannah, MA[1]; Risch, Elizabeth, MA[2]; Smith, River, MA[1]; Tiegreen, Sara, MA[1]; Newman, Elana, PhD[1]

[1]University of Tulsa, Tulsa, Oklahoma, USA
[2]Clinical Psychology, University of Tulsa, Tulsa, OK, USA

Preliminary research has identified a relationship between emotional dysregulation and posttraumatic stress disorder (PTSD) symptoms. Researchers have found statistically significant relationships between the Difficulties in Emotional Regulation Scale (DERS) scores and the PTSD Checklist (PCL-C) scores in a college student sample, suggesting that higher emotional dysregulation is related to symptoms of PTSD. The current study sought to replicate previous findings and to further explore the relationship between emotional dysregulation and PTSD symptoms by determining if DERS scores differed among subjects with either high or low trauma exposure. Preliminary analysis of the first 52 participants recruited indicated a statistically significant positive correlation between the DERS and PCL-C, with higher levels of dysregulation associated with higher levels of posttraumatic stress symptoms. Dividing the groups into high (5+ exposures) and low trauma (4 or less) exposure, using the Multiple Stressor Scale (MSS), a one-way between-groups ANOVA revealed no significant differences between the groups' DERS scores. Thus extent of trauma exposure seems unrelated to DERS scores. Results may confirm previous findings of a positive relationship between emotional dysregulation and PTSD symptoms. These results are tentative and will be updated once the full data set is collected.

Poster # F-163 (withdrawn) **Exhibition Hall, 4th Floor**

Operating Characteristics of the PTSD Checklist (PCL) in a Military Primary Care Setting

(Abstract #196251)

Poster # F-164 (Assess Dx, Mil Emer) **Exhibition Hall, 4th Floor**

Gore, Kristie, PhD[1]; Prins, Annabel, PhD[2]; Freed, Michael C., PhD[1]; Liu, Xian, PhD[1]; Kuesters, Phoebe, BA[3]; Engel, Charles, MD, MPH[4]

[1]Walter Reed Army Medical Center, DoD Deployment Health Clinical Center, Uniformed Services University, Department of Psychiatry, Washington, District of Columbia, USA

[2]San Jose Sate University, Department of Psychology, National Center for PTSD, VA Palo Alto Health Care System, San Jose, California, USA

[3]Deployment Health Clinical Center, Walter Reed Army Medical Center, Washington, District of Columbia, USA

[4]Uniformed Services University, Department of Psychiatry, Walter Reed Army Medical Center, DoD Deployment Health Clinical Center, Bethesda, Maryland, USA

Normative data for the Posttraumatic Stress Disorder (PTSD) Checklist Civilian version (PCL-C) are needed for accurate case identification of symptomatic individuals. Large scale screening efforts rely on cutscores to determine prevalence rates, dictate treatment needs, and describe population characteristics; however, the psychometric properties of the PCL-C in military primary care settings are largely unknown. We sought to describe the operating characteristics of the PCL-C for Department of Defense (DoD) healthcare beneficiaries seen in primary care. We conducted 213 PTSD diagnostic interviews and evaluated the PCL against the PTSD Symptom Scale Interview (PSSI) diagnosis. Receiver Operating Characteristics curves revealed the PCL-C accounted for 89% (95% confidence interval: 85%, 92%) of the area under the curve and a PCL-C score of 30 optimized sensitivity (0.93) and specificity (0.89). Multilevel likelihood ratios for PCL scores of 30, 44, and 50 were 4.28, 9.48, and 19.50 respectively. Mean (standard deviation) PCL scores were 50.8, (Ò15.0) for those with PTSD and 25.5(Ò11.3) for those without PTSD [t(210) = 12.2, p<.001]. Internal consistency was α = 0.97 and test-retest reliability after a median 13 days was 0.87 (n=112). These findings offer DoD primary care providers important data to interpret PCL scores and inform treatment decisions.

Symptoms of Pain on Posttraumatic Stress Disorder and the Impact of Treatment on Them

(Abstract #196252)

Poster # F-165 (Practice, Assess Dx) **Exhibition Hall, 4th Floor**

Costa, Ana Clara, BARCH[1]; Mello, Marcelo, PhD[1]; Pupo, Mariana, MCS[1]

[1]Psychiatry, Federal University at Sao Paulo, Sao Paulo, Brazil

Introduction: Posttraumatic Stress Disorder (PTSD) patients have impairment on their quality of life, the presence of pain are described as a common on these patients. The principal aim of this study is to evaluate the presence of pain symptoms on patients with PTSD, and also if there is an improvement on quality of life after treatment.

Method: A sample of 28 patients from the Program of Violence of Federal University of Sao Paulo, with PTSD diagnostic after a psychiatric semi-structured interview (SCID-I), completed the 36-Item Short-form Health Survey SF-36 (a self-report quality of life instrument), the Clinician-Administered PTSD Scale (CAPS) at baseline and after 3 months The patients received brief psychodynamic oriented psychotherapy, medication or the combination of both.

Results: PTSD patients had high levels of pain before treatment, which respond significantly to any treatment received. Although, the patients pain subscale scores on SF-36 remained too high even after treatment and their scores are higher than scores related on patients with rheumatoid arthritis.

Conclusion: PTSD patients have high pain scores and it was still high even after treatment which could be a risk of relapse factor.

Mediators and Moderators of Help-Seeking Behavior in Returning Iraqi and Afghanistan Veterans

(Abstract #196253)

Poster # F-166 (Mil Emer, Practice) **Exhibition Hall, 4th Floor**

Scotti, Joseph R., PhD[1]; Majewski, Virginia, PhD, MSW[2]; O'Riley, Alisa, MS[1]; Heady, Hilda, MSW[3]; Tunick, Roy, EDD[4]

[1]Department of Psychology, West Virginia University, Morgantown, West Virginia, USA

[2]Department of Social Work, West Virginia University, Morgantown, West Virginia, USA

[3]Office of Rural Health, West Virginia University, Morgantown, West Virginia, USA

[4]Department of Counseling, Rehabilitation Counseling, & Counseling Psychology, West Virginia University, Morgantown, West Virginia, USA

A state-wide survey of West Virginia Veterans who had one or more deployments in Iraq or Afghanistan was conducted over the period of November 2007 to March 2008. The 1,000 respondents (10% female; Mean age = 34) completed basic demographics and measures of combat exposure, PTSD, depression, personal and family functioning, and help-seeking behavior. Overall, 45% of the sample met criteria for PTSD and/or depression. Comparing veterans with PTSD/depression (P/D) with other veterans (OV) in the sample, the P/D veterans were significantly more likely than OV veterans to seek services at one or more levels (Informal, Support, Medical/crisis, Professional, Center/facility). However, P/D veterans were more likely than OV veterans to report low satisfaction with those services. We will present rates of help-seeking by level of service as moderated by age, gender, and urbanicity; as well as the mediational effects of level of combat exposure and self-reported impact on family relationships (significant other and children). We will discuss the relation of these findings to prior literature on variables associated with the willingness to seek mental health services, as well as the implications for providing treatment to this latest generation of combat veterans.

Cognitive-Affective Characteristics of Smokers With and Without PTSD and Panic Psychopathology

(Abstract #196255)

Poster # F-167 (Clin Res, Assess Dx) **Exhibition Hall, 4th Floor**

Vujanovic, Anka, BA[1]; Marshall, Erin, BA[1]; Kutz, Amanda, BA[1]; Nelson, Sarah, BA[1]; Zvolensky, Michael, PhD[1]

[1]University of Vermont, Burlington, Vermont, USA

The present study evaluated differences among daily smokers with and without PTSD and panic psychopathology (nonclinical panic attacks [PA], panic disorder [PD]) in terms of several cognitive-affective characteristics that may be implicated in the maintenance of smoking among these clinical populations. The sample consisted of 123 smokers (62% women) with a mean age of 29.7 years. Approximately 38.2% of the sample had a current primary diagnosis of PTSD; 13% had a current primary diagnosis of PD; 20.3% had current nonclinical PA; and 28.5% did not meet criteria for axis I psychopathology (control). A series of one-way analyses of variance and Tukey follow-up comparisons were conducted. In terms of anxiety sensitivity, agoraphobic cognitions, anxious arousal, depressive symptoms, worry, and perceived stress, the PTSD and PD groups reported significantly higher levels than the nonclinical PA and control groups (p's < .05). With regard to discomfort intolerance, the PTSD group reported significantly higher levels than the nonclinical PA and control groups (p's < .05), but the PD group did not differ significantly from any of the other groups. The PTSD group reported the greatest overall levels of all studied cognitive-affective variables. Theoretical and clinical implications of the findings are discussed.

Complex Posttraumatic Stress Symptoms Among a Community Sample of Battered Women

(Abstract #196258)

Poster # F-168 (Clin Res, Assess Dx) **Exhibition Hall, 4th Floor**

Leahy, Kerry, PhD[1]; Levendosky, Alytia, PhD[2]; Bogat, G., PhD[2]; Von Eye, Alexander, PhD[2]

[1]University of Michigan, Ann Arbor, Michigan, USA
[2]Michigan State University, East Lansing, Michigan, USA

Women who experience domestic violence (DV) are at risk for developing posttraumatic stress disorder (PTSD), as well as a range of potentially co-morbid mental health problems that exceed the intrusive, avoidant, and arousal symptoms of PTSD (e.g., depression, dissociation, interpersonal deficits; Nixon et al., 2004). Thus, the psychological sequelae of DV may be better captured by complex posttraumatic stress disorder (CP) - a syndrome developed to reflect the effects of chronic interpersonal trauma, including DV. This study's aim was to identify longitudinal patterns of DV victimization and to examine the relationship between these patterns and CP symptoms. Cluster analysis was used to structure 164 women's individual experiences of DV over six years. The cluster analysis produced a three-group solution: Minimal, Moderate, and High DV subgroups. ANOVA was used to examine whether number of CP symptoms differed as a function of DV cluster membership. Results were significant, such that greater DV was related to more CP symptoms. Findings suggest that women with moderate or high levels of DV are at risk for cognitive, affective, and behavioral dysregulation that transcends simple PTSD and may be better accounted for by CP. Results have significant clinical implications for the treatment of women who experience DV.

Poster # F-169 (withdrawn)

PTSD & the Anxiety Disorder Spectrum: Comparative Symptom Profiles

(Abstract #196263)

Poster # F-170 (Assess Dx, Clin Res) **Exhibition Hall, 4th Floor**

Karlsson, Marie, BS[1]; McTeague, Lisa, PhD[1]; Shumen, Joshua, BS[1]; Laplante, Marie-Claude, PhD[1]; Bradley, Margaret, PhD[1]; Lang, Peter, PhD[1]

[1]Clinical & Health Psychology, University of Florida, Gainesville, Florida, USA

The goal of the current study was to characterize the symptom and demographic profiles of PTSD in relation to other anxiety and mood disorders. Treatment-seeking individuals and controls (N=536) with diagnoses determined via administration of the ADIS-IV completed an extensive battery of questionnaires. The sample consisted of patients with principal diagnoses of PTSD (n=57), specific phobia (n=65), social phobia (n=79), panic disorder with (n=69) and without agoraphobia (n=36), GAD (n=74), OCD (n=38), depression (n=38), and a demographically-matched control group (n=80). Across a range of symptom domains including fearfulness, anxiety sensitivity, trait anxiety, cognitive and somatic symptoms of depression, anhedonia, anger, life events, and illness intrusiveness, PTSD patients consistently endorsed the greatest symptom severity. Furthermore, PTSD was accompanied by the highest rate of Axis I comorbidity. The pervasive and intense dysphoria reported by this group was more over associated with decrements in functional status. In particular, PTSD patients indicated the lowest household income and educational and occupational attainment, accompanied by the highest rate of divorce. These data underscore that even in relation to conceptually similar disorders, the broad distress and functional interference associated with PTSD are pronounced.

Links Between Childhood Trauma, Shame and Adult Psychopathology

(Abstract #196264)

Poster # F-171 (Clin Res,Prev EI) **Exhibition Hall, 4th Floor**

Frick, Kayla, Undergraduate Student[1]; Hill, Ryan, Undergraduate Student[2]; Cameron, Heather, BS[3]; Fezzey, Amanda, BS[3]; Gholami, Bardia, MD[4]; Muzik, Maria, MD[5]

[1]Psychology, University of Michigan, Franklin, Armed Forces Middle East, USA
[2]University of Michigan, Flat Rock, Michigan, USA
[3]Psychiatry, University of Michigan, Ann Arbor, Michigan, USA
[4]Department of Psychiatry, University of Michigan, Ann Arbor, Michigan, USA
[5]University of Michigan, Ann Arbor, Michigan, USA

Prior research has identified shame as possible mediator between childhood trauma and subsequent psychopathology, particularly to symptoms of depression and PTSD. However, less work has been done on investigating the associations between different forms of childhood trauma, shame and adult psychopathology. This current project, drawing mothers with their young children from the Maternal Anxiety During the Childbearing Years (MACY) study, aims to address this research question. Measures used are the Childhood Trauma Questionnaire (CTQ), the Shame Posture Measure, the National Women's Study PTSD Module, and the Post-Partum Depression Screening Scale. Data on the first nine participants, split into a group of mothers with high shame ratings (n=5) and low shame ratings (n=4), were used for these preliminary analyses. Mothers falling into the high shame group showed stronger correlations between childhood trauma and subsequent adult depression (r=.60, p <0.28) compared to mothers in the low shame group (r=.41 p <0.59), while we did not find this pattern in relation to PTSD. for the final presentation we will have data on the full sample (n= 60) allowing us to explore unique associations of shame and psychopathology with childhood trauma types, frequency, and duration.

The Relationship Between Barriers to Care, Treatment Seeking Behavior, and PTSD in OIF/OEF Veterans

(Abstract #196265)

Poster # F-172 (Mil Emer, Res Meth) **Exhibition Hall, 4th Floor**

McSweeney, Lauren B., BA[1]; Papa, Anthony, PhD[1]; Suvak, Michael K., MA[2]; Litz, Brett T., PhD[3]

[1]Veterans Affairs Medical Center/ National Center for PTSD, Boston, Massachusetts, USA
[2]Veterans Affairs Medical Center, Boston, Massachusetts, USA
[3]National Center for PTSD (116B-2), Boston VA Medical Center, Boston, Massachusetts, USA

Research on the mental health effects in US military personnel returning from current deployments to Iraq and Afghanistan has shown that deployment and exposure to combat result in increased risk of PTSD. Service members who endorse mental health difficulties are most likely to report concerns about being stigmatized and endorse barriers to receiving mental health services (Hoge et al., 2004). To further understand the relationship between combat deployment and mental health care (e.g., Hoge et al, 2003) we examined survey responses of US military personnel who served in either Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF). forty US military personnel completed surveys that assessed the degree of exposure to war-zone stressors, attitudes about emotional disclosure and disclosure of symptoms, attitudes about mental health, PTSD symptoms, and the motivation to seek mental health care. Preliminary analyses revealed significant bi-variate associations between barriers to receiving mental health services, treatment seeking behavior, and PTSD such that reports of barriers to receiving mental health services and reluctance to seek treatment predicted PTSD.

Subsequent analyses (once data collection is complete) will examine whether treatment seeking behavior mediates the relationship between barriers to receiving mental health services and PTSD.

A New Cure for Trauma in an Old Form: Controversies and Potentialities in Western Shamanism

(Abstract #196267)

Poster # F-173 (Cul Div, Practice) **Exhibition Hall, 4th Floor**

Mann, Rachel, MA, , PhD[1]
[1]*MettaKnowledge for Peace, LLC, Charlottesville, Virginia, USA*

Among other contested meanings, shamanism is defined as a new religious, therapeutic, and spiritual movement in the West that arose in the late 20th century out of contact between indigenous cultures and Western academics and clinicians. Many people with PTSD are turning to healers who define themselves as "shamanic practitioners" or related nomenclature. In this presentation, the controversies over and potentiality for the treatment of trauma by this new movement will be addressed. Because western shamanism is often associated with New Age beliefs in spirits, reincarnation and other non-ordinary phenomena, shamanism as a practice is usually ignored, at best, laughed at or considered dangerous, at worst. Yet, if we are to take seriously the many social scientists and psychologists who are advocating integrating the healing and curative systems of local, indigenous healers in non-western cultures in addressing PTSD, similarly, we must take seriously new therapeutic movements in our midst. This presentation will both educate its audience about the perspectives and practices of western shamanism and its potential uses in the treatment of trauma.

Therapy for Sane Hallucinations

(Abstract #196271)

Poster # F-174 (Assess Dx, Cul Div) **Exhibition Hall, 4th Floor**

Herrick, Karen, PhD[1]
[1]*Center for Children of Alcoholics, Inc., Red Bank, New Jersey, USA*

1) Spiritual framework for clinical experiences
   a. Buddhism
   b. Hinduism
   c. Christianity
   d. Alcoholics Anonymous
2) What is Mental Illness?
3) Clients' Anomalous Experiences
   a. Synchronicity or Meaningful Coincidence
   b. Near-Death Experience
   c. After-Death Communication
   d. OOB Experience
   e. Electronic Voice Phenomena
   f. Reincarnation Relationships
4) The Soul—Your Pattern for Your Life

GOALS/OBJECTIVES:

- Based on the work of William James, the Father of American Psychology, and his colleagues' work presented Aug 6-10, 1889 to the International Congress of Experimental Psychology, which convened in Paris, attendees will be given an understanding of "what psychologists generally would describe as casual hallucinations of sane persons."
- A Gallop survey of 2005 showed that about three in four Americans (73%) hold some paranormal belief. The categories are: Extrasensory perception (ESP) - 41%, Haunted houses - 37%, Ghosts (spirits of the dead returning) - 32% - Mental telepathy (communication between minds without using traditional senses) - 32%, Clairvoyance (the power of the mind to know the past and predict the future) - 26%, Astrology (the position of stars and planets can affect people's lives) - 25%, Witches - 21% and Reincarnation (rebirth of the soul in a new body after death - 20%. A Harris poll, at approximately the same time, stated for the age group 25-29, 40% of then believed in reincarnation. One out of twenty people in the United States are now having Near-Death experiences. Attendees will have a greater understanding of these paranormal experiences and/or cultural beliefs of their clients. Many times these experiences are linked to a history of childhood trauma which causes dissociative symptoms.
- To increase the knowledge of attendees regarding the conceptual focus of Dr. Raymond E. Moody, Jr. Dr. Moody coined the term Near-Death Experience in 1975 in his book Life after Life. One process he describes is that of Pretergression, which justifies the paranormal as a source of new knowledge. Pretergression helps to explain how a Jungian archetype comes into a client's awareness and aids in lifting symptoms of mental illness.
- To increase the networking opportunities in order that attendees may have conversations among themselves which may increase their learning about SEs and spirituality which could lead to a higher level of spiritual understanding personally and professionally.

Interpersonal Group Therapy for Chronic PTSD Patients Victims of Urban Violence

(Abstract #196272)

Poster # F-175 (Clin Res, Disaster) **Exhibition Hall, 4th Floor**

Campanini, Rosaly, MD[1]**; Ferri Schoedl, Aline, MD**[1]**; Pupo, Mariana, MCS**[1]**; Mello, Marcelo, PhD**[1]**; Costa, Ana Clara, BARCH**[1]
[1]*Psychiatry, Federal University of Sao Paulo, Sao Paulo, Brazil*

PTSD is a prevalent disorder that causes severe impairment on social, occupational and interpersonal functioning. Interpersonal therapy (IPT) is a treatment based on life events associated on triggering and maintenance of psychiatric disorders. IPT adapted for PTSD is a non expositive treatment that focused on traumatic interpersonal consequences. These consequences are withdrawal, distrust, low self-esteem, fear of intimacy, and vulnerability on social interactions. IPT-G helps patients to solve their interpersonal problems, either by other group member's feedback, as their own group experiences. During the sessions the patients have opportunity of having healthy social interactions. The study includes 30 PTSD patients which didn't respond to previous pharmacological treatment. The aim of the study was to evaluate the 16-week IPT-G adapted to PTSD efficacy to treat PTSD on this sample. The outcomes were PTSD (CAPS), depression (BDI) symptoms, quality of life (SF-36) and social functioning (SAS) after 3 and 6 months after the end of treatment. Results: Patient which received IPT-G adapted to PTSD responded with a decreasing CAPS, SAS and SF-36.

Military Sexual Trauma, Intimate Partner Violence, and Pain in Female Veterans in Primary Care

(Abstract #196275)

Poster # F-176 (Assess Dx, Mil Emer) **Exhibition Hall, 4th Floor**

Morrison, Jay, MA[1]**; Scioli, Erica, PhD**[1]**; Otis, John, PhD**[1]
[1]*VA Boston Healthcare System, Boston, Massachusetts, USA*

Military Sexual Trauma (MST) and Intimate Partner Violence (IPV) among female veterans continues to be a high research priority, particularly given the frequent co-occurrence of Posttraumatic Stress Disorder (PTSD) and pain conditions. This study compared pain and PTSD in female veterans who have experienced MST, IPV, and combat. Women with routine appointments in the Primary Care Clinic of the VA Boston Healthcare System (n=46) completed a self-report questionnaire of clinical and pain-related information. Of those responding, 74.4% received unwanted sexual attention and 48.8% were forced to have sex against their will while in the military. Further, 65.9% had been hit or threatened by their partner.

forced sex while in the military was related to PTSD symptoms (r=-.80, p<.0001) and depression (r=-.41, p<.01) while combat exposure was not. The majority (78.3%) also reported pain, with an average intensity of 6.4/10 over the last three months. IPV was associated with number of pain sites (r=-.43, p<.01) and number of different treatments for pain (r=-.41, p<.01). PTSD symptoms were also related to overall pain interference (r=.67, p<.004). This data adds to the literature documenting the high prevalence of MST and IPV in female veterans and the relationships these experiences have to PTSD and pain.

Combat PTSD: Related Issues and Treatment Approaches

(Abstract #196283)

Poster # F-177 (Mil Emer, Practice) **Exhibition Hall, 4th Floor**

Perez, Norma, PhD[1]; Eckler, Johanna, PsyD[2]

[1]PTSD Clinical Team, Central Texas Veterans Health Care System, Cedar Park, Texas, USA

[2]PTSD Clinical Team, Central Texas Veterans Health Care System, Austin, Texas, USA

With recent world events, the topic of PTSD and trauma has come to the forefront for many mental health providers. Along with this has come a flurry of research into the disorder and its treatment. This presentation will provide an overview of PTSD and related issues. This will be followed by an explanation of the empirically validated treatments currently available for PTSD as well as the research that has been done on these treatment modalities. The presentation will conclude with a description of how these treatments are being implemented in a PTSD clinic within the VA system with combat veterans from conflicts ranging from WWII to the current conflicts in Iraq and Afghanistan. As part of this workshop, practical issues such as clinician self-care and implementation will be covered.

Sleep Therapy Group Intervention for Combat Veterans

(Abstract #196285)

Poster # F-178 (Clin Res, Mil Emer) **Exhibition Hall, 4th Floor**

Thompson, Karin, PhD[1]; Franklin, C. Laurel, PhD[2]; Hubbard, Karen, PhD[3]; Risch, Elizabeth, MA[4]

[1]VA Medical Center Memphis, Memphis, Tennessee, USA

[2]Southeast LA Veterans Healthcare System, New Orleans, Louisiana, USA

[3]VA Medical Center San Antonio, San Antonio, Texas, USA

[4]Clinical Psychology, University of Tulsa, Tulsa, Oklahoma, USA

Sleep disturbance, one of the most widely reported symptoms after psychological trauma (Kilpatrick, Resnick, & Freedy, 1998), is a hallmark symptom of posttraumatic stress disorder (PTSD). Chronic insomnia affects emotional functioning and performance (Woodward, 1993; Inman, Silver & Doghramji, 1990). Among veterans returning from war, difficulty sleeping is a frequent complaint and is disruptive to post-deployment adjustment. Among veterans with chronic PTSD, sleep disturbance can last years or decades. A rigorous scientific review by the National Institutes of Health (2005) led to the conclusion that cognitive-behavioral therapies (CBT) have demonstrated efficacy in the treatment of insomnia, whereas most medications currently in use have not. However, the panel noted that CBT for insomnia is not widely used because many clinicians are not trained in this approach. Two studies of CBT treatment for insomnia among trauma survivors are available, and although both are uncontrolled, they show promise for CBT group treatment of sleep disturbance in fire evacuees (Krakow et al., 2002) and crime victims (Krakow et al., 2001). This poster will describe a manualized group treatment intervention using cognitive-behavioral techniques to address sleep disturbance among combat veterans with PTSD along with pre-post measures of insomnia, sleep quality, and PTSD symptoms.

Preliminary Psychometric Properties of a Generating Meaning Self-Efficacy Scale Following Trauma

(Abstract #196292)

Poster # F-179 (Res Meth,Prev EI) **Exhibition Hall, 4th Floor**

Waldrep, Edward, Undergraduate[1]; Benight, Charles C., PhD[1]; Cieslak, Roman, PhD[1]

[1]University of Colorado, Colorado Springs, Colorado, USA

The purpose of this study was to develop a scale to measure individual's belief in their ability to generate meaning (MSE) after a trauma. One-hundred fifty-seven students completed an online survey through an online research program. The scale originally consisted of 19 items but the corrected item-total correlation suggested that removal of one of the items would increase the Cranbach's alpha level. The final scale consists of 18 items and with a Cronbach's alpha of .91. Factor analysis of the scale indicated one primary factor accounting for 43% of the variance and each item reporting a factor loading greater than .35. The MSE scale is positively correlated to a scale of coping self-efficacy ($r = .65$, $p < .01$) and negatively correlated to the posttraumatic check list ($r = -.22$, $p < .01$) suggesting that higher MSE is related to lower posttraumatic distress. The developed scale was also related to the Marlowe-Crown Social Desirability Scale ($r = .29$, $p < .01$), but controlling for this effect the correlation between the CSE and PTSD symptoms was still significant and in the predicted direction. The MSE scale appears to be measuring the intended construct and reports a high level of internal reliability, though further analysis of test-retest reliability and construct validity are needed to more fully validate the scale.

The Role of Race and SES in Predicting Psychopathology Following the 9/11/2001 WTC Attacks

(Abstract #196295)

Poster # F-180 (Assess Dx, Cul Div) **Exhibition Hall, 4th Floor**

Dugan, Kelly, MA[1]; Nomura, Yoko, PhD[2]; Jones, Russell T., PhD[1]; Abramovitz, Robert H., MD[3]; Chemtob, Claude M., PhD[2]

[1]Psychology Department, Virginia Polytechnic Institute and State University, Blacksburg, Virginia, USA

[2]Department of Psychiatry and Pediatrics, Mount Sinai School of Medicine, New York, New York, USA

[3]Jewish Board of Family & Children's Services, Inc., New York, New York, USA

The role of race as a risk factor for developing posttraumatic stress symptoms following a trauma has been widely researched. A recent meta-analytic review of the literature found evidence to support the notion that minority groups display more distress and/or fare poorly compared to majority groups following traumatic events. Comparatively, other studies have addressed the possibility of the confounding effects of SES. Further, when SES has been controlled for, race/ethnicity no longer statistically predicted differences in the development of PTSD. The current study attempted to address the impact of race and a variety of socioeconomic variables on the development of PTSD and depression following a traumatic event. It was hypothesized that race would be significantly correlated with psychopathology but that this relationship would decrease when SES variables were controlled for. Data was collected as part of a larger study assessing the effects of the September 11th, 2001 WTC attacks on families with young children that were directly affected. Depression and posttraumatic stress symptoms were obtained via self-report (CES-D and PDS, respectively), along with a multitude of demographic variables, including race, education level and occupation. Analyses in progress are examining each variable's ability to predict psychopathology.

Poster # F-181 (withdrawn)

The Impact of Terror on Humanitarian Aid Workers and Models of Support

(Abstract #196301)

Poster # F-182 (Civil Ref, Commun) **Exhibition Hall, 4th Floor**

Dubrow, Nancy, PhD[1]; McNulty, Michael, PhD[2]; Curling, Penelope, MA[3]

[1]Taylor Institute, Chicago, Illinois, USA
[2]Clinical PsyD Program, The Chicago School of Professional Psychology, Chicago, Illinois, USA
[3]UNICEF, New York, New York, USA

This presentation will address work in dealing with the impact of terror on local and international humanitarian aid workers in Sri Lanka, the Middle East and Africa. Models of culturally sensitive support for in-country aid workers will be presented. Self-care for consultants and counsellors will be discussed.

Supporting Local Humanitarian Aid Workers
In the month that followed the tsunami, the presentor traveled to Sri Lanka to assist counseling psychologist, Fr. Paul Satukunanagam, S.J., and his agency, The Professional Psychological Counselling Centre of Batticaloa (PPCC). Since that time, he has made five more visits to this area to provide consultation and workshops on basic counseling skills to local counselors who are mostly paraprofessionals trained in other fields. He will tell the story of his work in Batticaloa, which is adjacent to a war zone, and prone to natural disaster. He will discuss PPCC's "Barefoot Counsellors'" efforts to assist survivors with chronic stress, trauma, and ambiguity, in a culture where therapy is a foreign concept, and the language lacks words for psychological terms. He will describe the progress of a team at The Chicago School of Professional Psychology working (a) to bring a subgroup of the counselors to the USA for intensive training and (b) to develop a counselor certificate program with workshop and online components to ensure counselors will have a more systematic and culturally relevant approach to their training. Self Care for Consultants Working with international populations who live in situations of armed conflict presents many extraordinary learning opportunities as well as extreme challenges. This presentation will focus on the author's experience as a psychosocial consultant for aid agencies in Africa and the Middle East. Developing support services for internally displaced persons and refugees, child soldiers and victims of violent traumatic events facilitates the consultants' deep understanding of their experiences. Living and working in culturally diverse settings informs the implementation of psychosocial interventions. While these experiences would challenge many intellectually, the emotional challenge of living and working in situations of armed conflict is perhaps the most difficult – while in country, when departing and when one returns home.

Supporting International Humanitarian Aid Workers
Supporting humanitarian aid workers in the aftermath of terror Humanitarian aid workers often work in difficult environments, including physical hardship and danger. Witnessing the impact of war, civil strife and disasters on beneficiary populations can be extremely difficult to process, especially when one is far from one's home, family and friends. Increasingly, humanitarian aid workers have themselves become the target of direct acts of terror. Recognizing the need for support to their staff members in these circumstances, a number of humanitarian aid agencies have initiated staff support systems. This presentation will discuss the author's experiences working as a staff counsellor to an international agency, providing support to colleagues working in conflict and post-conflict situations all over the world, and will highlight a mission to support injured colleagues in the aftermath of a terrorist attack, where the 'testimony' method of debriefing was found to be most helpful.

Impaired Fear Inhibition in PTSD is Associated With HPA Function

(Abstract #196302)

Poster # F-183 (Bio Med, Clin Res) **Exhibition Hall, 4th Floor**

Jovanovic, Tanja, PhD[1]; Norrholm, Seth, PhD[1]; Blanding, Nineequa, BS[2]; Bradley, Rebekah, PhD[1]; Duncan, Erica, MD[1]; Ressler, Kerry, MD, PhD[3]

[1]Psychiatry & Behavioral Sciences, Emory University, Decatur, Georgia, USA
[2]Emory University, Marietta, Georgia, USA
[3]Psychiatry and Behavioral Sciences, Emory University, Atlanta, Georgia, USA

A central problem in posttraumatic stress disorder (PTSD) is the inability to suppress fear under safe conditions. Previously, our lab has shown that civilian- and combat-related PTSD patients cannot discriminate between danger and safety. Observed alterations in HPA function in PTSD may be associated with impaired fear inhibition. This study examined HPA function and fear-potentiated startle (FPS) in trauma-exposed individuals with and without PTSD. We used a conditional discrimination procedure, in which one set of lights (CS+) was paired with aversive airblasts to the throat, and different lights (CS-) were presented without airblasts. In addition to FPS, blood was drawn for neuroendocrine analysis and the dexamethasone suppression test (DST) was performed; cortisol and ACTH were assessed at baseline and post-DST. There were no group differences in baseline or post-DST cortisol or ACTH. However, in non-PTSD subjects, FPS to the CS+ was negatively correlated with post-DST ACTH levels ($r=-0.53, p=0.01$), while in PTSD subjects, FPS to the CS+ was positively correlated with post-DST ACTH ($r=0.71, p<0.05$). Furthermore, PTSD subjects also showed a positive correlation between FPS to the CS- and post-DST ACTH ($r=0.84, p<0.01$), while non-PTSD subjects did not. These results suggest that impaired fear inhibition may be associated with ACTH feedback function.

The Aftermath of War Trauma Exposure on Military Couples

(Abstract #196305)

Poster # F-184 *(Mil Emer, Res Meth)* **Exhibition Hall, 4th Floor**

Baptist, Joyce, PhD[1]; Garrett, Kevin, MED[1]; Amanor-Boadu, Yvonne, MS[1]; Sanders-Hahs, Erin, BS[1]; Nelson Goff, Briana, PhD[1]

[1]Kansas State University, Manhattan, Kansas, USA

Traumatic events affect the individual trauma survivor and their significant relationships. The literature on traumatic stress mainly focuses on the individual. The couple relationship, a primary and important unit, provides a unique context for examining the interpersonal impact of post-trauma responses.

This poster will present results from a mixed method study that used quantitative measures and qualitative interviews to examine the impact of post-trauma responses. Participants included a total of 30 individuals comprised of soldiers who had recently returned from deployment to a war zone and their partners.

The analysis of the interview data found five ways trauma affects the couple relationship: communication, roles, coping, intimacy and emotions.

Trauma Research Teams: A Template for Design, Development and Administration

(Abstract #196307)

Poster # F-185 (Res Meth, Media) **Exhibition Hall, 4th Floor**

Garrett, Kevin, MED[1]; Baptist, Joyce, PhD[1]; Sanders-Hahs, Erin, BS[1]; Nelson Goff, Briana, PhD[1]

[1]Kansas State University, Manhattan, Kansas, USA

This presentation provides a template to design, develop, and administrate research teams. The template will be used to illustrate the research process of a study of trauma in military couples. It provides an infrastructure for the management of research teams that involves two overarching steps: the foundational work and the research process.

The foundational work provides the common aspects of establishing the research team, entails the articulation of the study purpose and expected outcomes, and the design, development, and administration of the research team. The research process involves tasks common to different research projects, as well as other tasks unique to a specific project.

Validity Study of the Brazilian Version for Early Trauma Inventory

(Abstract #196309)

Poster # F-186 (Assess Dx, Clin Res) **Exhibition Hall, 4th Floor**

Schoedl, Aline, MCS[1]; Mello, Marcelo, PhD[1]

[1]Universidade Federal de Sao Paulo, Sao Paulo, Brazil

Introduction: The presence of early life stress (ELS) is a strong predictor of future psychopathology during adulthood.The aim of this study was to investigate the psychometrics properties of a Brazilian version of Early Trauma Inventory (ETI).

Method: The ETI is a 52- item inventory designed to assess traumatic experiences that happened up to 18-years old. The ETI was translated to Portuguese.The ETI was administered to subjects which were exposed to a severe stressor event after they were administered a standard diagnostic interview. Those which found to meet *DSM-IV* criteria for a diagnosis of posttraumatic stress disorder (PTSD) were enrolled as experimental subjects, and as control subjects which were exposed to a stressor event but did not develop PTSD or any other mental disorder. Results: Ninety-one (91) patients with a PTSD diagnosis and twenty-nine (29) control subjects were enrolled in the study. The ETI total showed a .9 internal consistency index. The reliability was test-retest (.8) and inter-raters (.9). The Cut-point determined by ROC curve was a 63 score (specificity of 67% and sensitivity of 71%). There was a positive correlation between total ETI and CAPS scores (r=0,698 p=.042). ETI showed a good construct validity for extreme groups.Conclusion: The Brazilian version of the ETI is a valid and reliable instrument for clinical and scientific.

Prospective Study of Escape-Avoidance Coping and PTSD Symptoms in Police

(Abstract #196312)

Poster # F-187 (Mil Emer,Prev El) **Exhibition Hall, 4th Floor**

Richards, Anne, MD, MPH[1]; Henn-Haase, Clare, PsyD[1]; Metzler, Thomas, MA[1]; Neylan, Thomas, MD[1]; Marmar, Charles, MD[1]

[1]University of California San Francisco, San Francisco, California, USA

Exposure to a traumatic stressor is a necessary but insufficient condition for the development of PTSD. Additional factors, including coping styles, are hypothesized to contribute to PTSD. Escape-avoidance coping may be considered a mechanism that inhibits habituation to trauma-related anxious arousal, resulting in persistence of PTSD symptoms. The following hypotheses were tested in a prospective study of 221 police academy recruits, who were PTSD-negative at baseline, and were reassessed after 1 year of police service: (1) Greater use of escape-avoidance coping in response to critical incident stressors will be associated with greater PTSD symptoms at 1 year and (2) Greater use of escape-avoidance coping will mediate the relationship between severity of exposure and PTSD symptoms at 1 year.

Results of linear regression analysis confirmed that escape-avoidance coping predicts PTSD symptoms at 1 year, controlling for demographic variables, baseline psychopathology, severity of traumatic stressor and peritraumatic dissociation and distress (beta = 0.23, p < .001). Controlling for covariates, critical incident exposure severity predicts PTSD symptoms at 1 year (beta = .17, p = .011), and this effect is partially (23%) mediated by escape-avoidance coping (Sobel test = 2.54, p = .011). These findings have implications for the prevention and treatment of PTSD.

Brief Assessment of Anger in a Sample of U.S. Veterans With Posttraumatic Stress Disorder

(Abstract #196314)

Poster # F-188 (Assess Dx, Clin Res) **Exhibition Hall, 4th Floor**

Santanello, Andrew, PsyD[1]; Ranucci, Melissa, MS[2]; Decker, Melissa, PsyD[3]; Batten, Sonja V., PhD[1]

[1]Trauma Recovery Programs, Veterans Affairs Maryland Health Care System, Baltimore, Maryland, USA
[2]University of North Texas, Denton, Texas, USA
[3]VA Maryland Health Care System, Baltimore, Maryland, USA

Anger is a common presenting problem for veterans with Posttraumatic Stress Disorder (PTSD) and is associated with impairment in functioning in many domains. Given the prevalence and consequences of anger problems, there is a need for brief measures of anger that do not pose undue burden upon patients or research participants. Based on the need for a more concise measure of anger in the PTSD population, recent research has investigated the psychometric properties of the Dimensions of Anger Reactions Scale (DARS) in an Australian combat-veteran population (forbes et al., 2004). The present study compared the DARS to the Trait Anger Scale (TAI) and the State Anger Scale (SAI) in an American veteran population. A correlational analysis revealed that the DAR was significantly positively correlated with Trait Anger (r = .64, p<.01). The DAR was less strongly positively associated with State Anger (r = .34, p<.01). The correlation between the DAR and Trait Anger was lower than that suggested by previous research and possible reasons for this discrepancy are discussed. Potential advantages of using this more concise measure of anger in both clinical and research settings are considered.

Personality and Coping: Developing a Predictor Model for Trauma-Related Risk-Taking

(Abstract #196316)

Poster # F-189 (Practice, Clin Res) **Exhibition Hall, 4th Floor**

Siebenmorgen, Marsha, BA[1]; Davis, Joanne, PhD[2]; Elhai, Jon, PhD[3]

[1]University of Tulsa, Tulsa, Oklahoma, USA
[2]Psychology, University of Tulsa, Tulsa, Oklahoma, USA
[3]Psychology, University of South Dakota, Vermillion, South Dakota, USA

Research suggests a relationship between personality, coping, and risk-taking behaviors. However, limited research has considered how personality relates to risk-taking behaviors in trauma-exposed individuals. This study examines personality characteristics, avoidant coping styles, and risk-taking behaviors among a trauma-exposed sample. Positive Emotionality (PEM), Negative Emotionality (NEM), and Constraint (CON) as assessed by the Multidimensional Personality Questionnaire - Brief form (Patrick, Curtin, & Tellegen, 2002) was observed and the following was hypothesized: 1) avoidant coping would be positively related to risk-taking 2) avoidant coping would operate as a moderator within the trauma and risk-taking relationship 3) social closeness (PEM),

stress reaction (NEM), and harm avoidance (CON) would be associated with risk-taking. Preliminary analyses from 65 individuals support hypotheses one and two suggesting a significant relationship between avoidant coping styles and risk-taking behaviors, with avoidant coping acting as a significant moderating variable. However, hypothesis three did not receive support: social closeness, harm avoidance, and stress reaction did not have a significant relationship with risk-taking behaviors. Preliminary results provide support for future assessment of personality, coping, and risk-taking in trauma-exposed individuals.

Mind, Body and Art: Alternative Interventions in the Treatment of PTSD

(Abstract #196317)

Poster # F-190 (Practice, Commun) **Exhibition Hall, 4th Floor**

Rhode, Barbara, BA, MS, LMFT, CISD[1]; Neilson, Chris, BA, CAP[2]
[1]Transitions & You, St. Petersburg, Florida, USA
[2]Goodwill Corrections Center, St. Petersburg, Florida, USA

Individuals in court ordered drug treatment facilities are often forgotten trauma victims, who are typically not exposed to alternative intervention. This workshop will provide a unique clinical approach in the assessment and treatment of PTSD as demonstrated through inmates at the Goodwill Correctional Facility - 65% of which are diagnosed with PTSD. Through the collaborative efforts of a licensed psychotherapist and community resources, inmates are offered a diverse program of therapeutic arts, yoga, deep breathing meditation and group therapy. These services are having a profound effect on the long term well being of the inmates and their families.

Personal Need for Structure and Trait Anger in a Sample of U.S. Veterans With PTSD

(Abstract #196318)

Poster # F-191 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Santanello, Andrew, PsyD[1]; Ranucci, Melissa, MS[2]; Decker, Melissa, PsyD[3]; Batten, Sonja V., PhD[1]
[1]Veterans Affairs Maryland Health Care System, Baltimore, Maryland, USA
[2]University of North Texas, Denton, Texas, USA
[3]VA Maryland Health Care System, Baltimore, Maryland, USA

Anger is a common problem for individuals diagnosed with PTSD. Even among those who have been successfully treated for PTSD with cognitive-behavior therapy, anger is among the most frequently reported residual symptoms (e.g., Zayfert & DeViva, 2004). The persistence of anger problems in successfully treated clients suggests that these problems may be maintained by different mechanisms than those that maintain other posttraumatic symptoms. This study investigated the relationship between Personal Need for Structure (Neuberg & Newsome, 1993) and Trait Anger (Spielberger, 1988) in a sample of US Veterans with PTSD (N=83). Results suggest that Personal Need for Structure and Trait Anger have a significant, positive relationship that is independent of posttraumatic symptom severity. Potential implications of these findings for future research and treatment of posttraumatic anger will be discussed.

Dream Therapy for PTSD in a Policeman

(Abstract #196321)

Poster # F-192 (Practice, Clin Res) **Exhibition Hall, 4th Floor**

Dow, Bruce, MD[1]
[1]Psychiatry, University of California, San Diego, California, USA

Dream therapy was conducted with a policeman on disability leave for posttraumatic stress disorder (PTSD). He remained off work for one year, returned to limited duty for another 20 months, and then returned to full duty. His progress in therapy is reflected in a series of 44 dreams over a 4 year period, including his disability and recovery. Initially he is tormented by nightmares of being pursued (by a dog, a tidal wave, a shark). Following instruction in dream revision techniques some months into the therapy, his dreams undergo a variety of major changes. In different dreams he 1) shoots the dog, 2) finds practical uses for the tidal wave, 3) becomes the shark, and 4) locates an attractive female companion to run with and assist him (James Bond scenario). The full dream series illustrates the usefulness of dream revision instruction and longterm followup in the course of a successful therapy for PTSD in a policeman.

Participant Alert: The patient to be described in the presentation was exposed to graphic violence in the course of his work as a policeman.

Ecological Approach to Child Outcomes Following Residential Fire: Family Processes and Child Coping

(Abstract #196323)

Poster # F-193 (Practice, Child) **Exhibition Hall, 4th Floor**

Moore, Rachel, BA[1]; Jones, Russell, PhD[1]; Ollendick, Thomas, PhD[1]
[1]Clinical Psychology, Virginia Polytechnic Institute and State University, Blacksburg, Virginia, USA

The present study applies the Transactional Stress and Coping (TSC) model (primarily used in child chronic health literature) to predict child outcomes following residential fire. In the present study, child adjustment following residential fire (e.g., PTSD, depression, anxiety) is expected to be mediated by child adaptational (cognitive appraisals, coping methods) and family processes. Participants were 144 children/adolescents (ages 7 to 18) and their parents, who had experienced a residential fire. Results indicate that family conflict (= .289, $p < .05$) mediates the relationship between children's overall adjustment at 4-months and parent reports of child internalizing symptoms at 11-months post-fire (= .235, $p > .05$). Results also indicate avoidant coping strategies (= .294, $p < .05$) mediate the relationship between child anxiety/depression at 4-months and PTSD symptoms at 11 months (= .246, $p > .05$). Furthermore, results indicate that family conflict (= .279, $p < .05$) also mediates the relationship between children's self-reported anxiety/depression at 4-months and parent report of child internalizing symptoms at 11-months (= .244, $p > .05$). These results suggest a transactional relationship among family environmental variables and individual child adaptational processes which may predict adjustment outcomes.

Self-Efficacy Moderates the Relationship Between Discrimination and PTSD in People With HIV

(Abstract #196324)

Poster # F-194 (Ethics,Prev El) **Exhibition Hall, 4th Floor**

Yadavalli, Suhrida, MS[1]; Boarts, Jessica, MA[1]; Delahanty, Doug, PhD[1]

[1]Kent State University, Kent, Ohio, USA

The present study investigated whether self-efficacy acted as a moderator between stress from discrimination based on race, MSM status and HIV-positive status and PTSD symptoms (PTSS) in 84 HIV-infected men and women. African Americans constituted fifty percent of the sample. Self-efficacy was defined as an individual's perceived ability to perform a specified behavior or set of behaviors. Participants were recruited from a social service agency and completed questionnaire packets twice, three months apart. A Structural Equation Model revealed a significant model fit for the association between stress from discrimination based on race, MSM status and HIV-positive status and PTSS. The model with self-efficacy as a moderator fit the data well, 2 (6, N=84) =10.12, p=.00, CFI=.98, SRMR=.04, RMSEA=.09. The paths from self-efficacy to PTSD symptom clusters of Avoidance and Intrusion were significant. The paths from the three types of discrimination to the Avoidance and Intrusion clusters were also significant. Results underscore the importance of examining the impact of discrimination and self-efficacy in people with HIV/AIDS. Future research is necessary to determine whether interventions to improve self-efficacy in PLWH can reduce the impact of discrimination and PTSS.

Battle Body Retraining: A Survey of Mind-Body Interventions for Returning OEF/OIF Veterans

(Abstract #196329)

Poster # F-195 (Mil Emer,Prev El) **Exhibition Hall, 4th Floor**

Proescher, Eric J., PsyD[1]

[1]Mental Health Service Line, Jesse Brown VAMC, Chicago, Illinois, USA

Available data on Iraq/Afghan veteran readjustment problems suggest high rates of mental health disorders including posttraumatic stress disorder (PTSD), depression, and alcohol use disorders (Hoge, C.W., Auchterlonie, J.L., & Milliken, C.S., 2006; Hoge, C. W., Castro, C. A., & Messer, S.C., 2004; Seal, K.H., Bertenhal, D., Miner, C.R., Sen, S., & Marmar, C., 2007). Many other veterans report problems with sleep, irritability, pain, and hyper-vigiliance during periods of normal readjustment (personal communication, Hoge 4/12/2007). Battle-Body Re-Training is an eight-week mind-body program for OEF/OIF veterans to reduce stress, enhance the immune system, and generate physical and emotional health. Military service members training for and participating in combat experience high levels of stress that can cause irregularities in the autonomic nervous system affecting states of sleep, restlessness, exaggerated startle, irritability, pain, and muscle tension. A survey of Mind-Body Interventions including but not limited to Deep Breathing, Autogenic Relaxation, Progressive Muscle Relaxation, Mindfulness Meditation, Tai Chi/Chi-Kung, Yoga, Reiki, Guided Imagery, Mantra Therapy, and Hypnosis can help-with regular practice-reestablish the equilibrium of Mind and Body. Case material will be used to illustrate clinical issues.

Theological Perspectives on Interpersonal Abuse: The Wounded Soul

(Abstract #196330)

Poster # F-196 (Practice, Clin Res) **Exhibition Hall, 4th Floor**

Lyon, Emily, PhD, MDIV[1]

[1]Religion and Psychology, Graduate Theological Union, Palo Alto, California, USA

A holistic view of the person includes body, mind and spirit, or soul. The purpose of this presentation is to open up the concepts of 'soul' and 'radical evil' within the conversation about terrifying interpersonal abuse. Most religions and spiritual disciplines understand the human person, especially the human soul, as sacred. When the perpetrator, propelled by his own internal alienation, desecrates the soul of his victim through relational sexual abuse, the victim often experiences herself as a no-person. Her ongoing sense of identity is fragmented, her capacity for spiritual experience, for imagination, creativity, relatedness are deeply wounded. With the help of understandings derived from neuroscience, as well as other theological perspectives, some pathways for healing of the soul are discussed.

Using Propranolol to Treat Patients Suffering From PTSD: The Importance of the Reconsolidation Theory

(Abstract #196332)

Poster # F-197 (Clin Res, Bio Med) **Exhibition Hall, 4th Floor**

Poundja, Joaquin, BSC[1]; Brunet, Alain, BCOMM, PhD[2]

[1]Psychologie, University de Montreal, Montreal, Quebec, Canada
[2]Douglas Hospital Research Center, Verdun, Quebec, Canada

In the past, we had the idea that once memories were consolidated in the brain, they were to remain perpetually unchanged in long-term memory. This view of memory has recently been modified with the theory of reconsolidation. The reconsolidation theory now states that an old memory, when reactivated (i.e., remembered), goes from long-term memory to short-term memory. In order to go back to long-term memory, it has to undergo a reconsolidation process. In other words, even once consolidated, an old memory can still be modified, and its strength can be attenuated. The reconsolidation theory have had an impact on the treatment of posttraumatic stress disorder (PTSD), as some researchers are now trying to develop a new treatment for PTSD based on reconsolidation processes, and using post-reactivation propranolol. This treatment aims at decreasing the strength of a traumatic memory that was consolidated from months to years before. In this presentation, as a first step we will review the literature on reconsolidation, and then we will provide a theoretical rationale as to how reconsolidation could be useful in the treatment of PTSD (using propranolol). This literature review will been done, searching in titles for the word 'reconsolidation' on PsycINFO (OVID) and EMBASE (OVID).

Peritraumatic Reactions: Predictors of Poor Response to Pharmacological Treatment for PTSD

(Abstract #196333)

Poster # F-198 (Assess Dx, Clin Res) **Exhibition Hall, 4th Floor**

Fiszman, Adriana, MD[1]; Mendlowicz, Mauro V., MD[2]; Marques-Portella, Carla, MD[1]; Volchan, Eliane, MD, PhD[3]; Coutinho, Evandro S.F., MD, PhD[4]; Figueira, Ivan, MD[5]

[1]Institute of Psychiatry - Universidade Federal do Rio de Janeiro, Rio de Janeiro, Brazil
[2]Department of Psychiatry and Mental Health, Universidade Federal Fluminens, Niterai, Brazil
[3]Institute of Biophysics Carlos Chagas Filho, Universidade Federal do Rio de Janeiro, Rio de Janeiro, Brazil
[4]Department of Epidemiology, Escola Nacional de Saude Publica, Rio de Janeiro, Brazil
[5]Institute of Psychiatry - Universidade Federal do Rio de Janeiro (UFRJ), Rio de Janeiro, Brazil

Despite mounting evidence that peritraumatic dissociation and panic are strong predictors of PTSD development, their impact on treatment outcome remains understudied. This study evaluated the role of peritraumatic dissociation, physical panic symptoms and tonic immobility as predictors of response to pharmacotherapy for PTSD. Thirty-six PTSD patients underwent a naturalistic pharmacological treatment according to the guidelines for PTSD. The Posttraumatic Stress Disorder Checklist - Civilian Version (PCL-C) was applied at baseline and endpoint. Peritraumatic reactions were assessed using the Physical Reactions Subscale (PRS), the Peritraumatic Dissociative Experiences Questionnaire (PDEQ) and four questions about motor symptoms of tonic immobility (TIQ-4). Simple and multiple linear regression models were fitted for TIQ-4, PRS and PDEQ as predictors of PCL-C endpoint scores. All three peritraumatic reactions were associated with poor response to treatment. However, after controlling for confounding variables, only tonic immobility maintained its association with poor outcome. Our finding that tonic immobility was stronger than dissociation and panic in predicting poor response to pharmacotherapy for PTSD suggests a prognostic value for tonic immobility as well as a possible distinct pathophysiology for PTSD patients reporting this peritraumatic reaction.

Occupational Trauma: Relative Contributions of Trauma Exposure and the Organizational Environment

(Abstract #196334)

Poster # F-199 (Mil Emer, Clin Res) **Exhibition Hall, 4th Floor**

Gray, Lori K., MA[1]; Jackson, Dennis L., PhD[1]

[1]Psychology Department, University of Windsor, Windsor, Ontario, Canada

Trauma exposure among emergency service providers occurs within the context of an overarching organizational environment. Accordingly, recent research has sought to ascertain how emergency service providers' organizational environment might impact the development of traumatic stress. Whereas various studies have provided evidence for a relationship between the organizational environment and traumatic stress, it is unclear whether the organizational environment actually adds to the prediction of traumatic stress symptoms, above and beyond the characteristics of trauma exposure. The objective of this study was to identify the relative contributions of trauma exposure and the organizational environment to the prediction of traumatic stress symptoms. Participants included a sample of Canadian firefighters. Results from hierarchical multiple regression analyses revealed that firefighters' organizational environment predicted a significant proportion of the variance in traumatic stress symptoms above and beyond trauma exposure. The specific aspects of the organizational environment that accounted for the significant findings will be discussed along with the implications for future research, clinical practice, and organizational intervention.

Influence of Prior Trauma in Low-Income Women of Color Exposed to Intimate Partner Violence

(Abstract #196335)

Poster # F-200 (Clin Res, Assess Dx) **Exhibition Hall, 4th Floor**

Wilson, Christina, MA[1]; Burnett, Christiane, MA[1]; Hoffman, Casey, MA[1]; Samuelson, Kristin, PhD[1]

[1]California School of Professional Psychology, Alliant International University, San Francisco, California, USA

This poster will present demographic and clinical characteristics of a sample of battered women who participated in a study examining predictors of PTSD symptoms. We assessed a non-shelter sample of 37 primarily low-income women with histories of intimate partner violence (IPV). Twenty women met diagnostic criteria for full or sub-threshold PTSD to the IPV, as measured by the CAPS, and 17 women did not meet criteria for PTSD. Seventy percent of the women were living below the poverty line, and many reported extensive trauma histories. Nineteen of the women had been in multiple IPV relationships, 71% witnessed IPV as children, 45% were abused as children, and 58% had experienced community violence. PTSD+ women were more likely to have experienced multiple violent relationships ($t = -2.19$, $p = .035$), consistent with research documenting a cumulative effect of trauma on PTSD status. However, the PTSD- women were more likely to have been exposed to community violence than the PTSD+ women ($t = 2.05$, $p = .048$). Some past research has suggested that women in high-violence communities become desensitized to violence; these results suggest that this desensitization might then protect against developing PTSD when confronted with interpersonal experiences of violence.

Coping Styles and Trauma Symptoms: The Relationship in Child Sexual Abuse Victims

(Abstract #196339)

Poster # F-201 (Child, Clin Res) **Exhibition Hall, 4th Floor**

Skinner, Sabrina, BA[1]; Bryant, Cody, BA[2]; Fiore, Christine, PhD[1]; Legerski, Joanna, MA[1]

[1]University of Montana, Missoula, Montana, USA
[2]Psychology, University of Montana, Missoula, Montana, USA

Adaptive strategies previously engaged to cope with child sexual abuse may become maladaptive and harmful in later life (Shapiro, 1999), "depending on how the events are perceived, appraised and processed" (Williams, 1993). A sub-sample obtained from an archival dataset of 394 battered women in Western Montana, age 18-58, containing a subset of 116 self-reported victims of Child Sexual Abuse (CSA) and 278 women reporting no history of CSA (No-CSA). The Ways of Coping questionnaire (WOC) (Folkman & Lazarus, 1988) was used to measure the women's approach to coping, and the Trauma Symptom Checklist (TSC) (Briere & Runtz, 1989) to measure trauma symptoms. It is hypothesized that women CSA victims' ways of coping (emotion-focused and problem-focused) will be associated with greater trauma symptoms compared to trauma symptoms of non-victims of CSA, all of whom experienced adult Intimate Partner Violence (IPV). Clarification of the relationship between coping approaches and psychological symptoms of trauma in women with histories of CSA is needed for clinicians, treatment providers, and program developers to produce more comprehensive behavior models to treat the complex outcomes associated with childhood trauma.

Reliability and Validity of Symptom Checklist 90 PTSD Scales (SCL-PTSD)

(Abstract #196341)

Poster # F-202 (Assess Dx, Clin Res) **Exhibition Hall, 4th Floor**

Bae, Hwallip, MD[1]; Han, Chang Woo, MD[2]; Park, Yong Chon, MD[3]; Kim, Daeho, MD[4]

[1]Hanyang University Guri Hospital, Gyeonggi, South Korea
[2]Military Manpower Administration, Seoul, South Korea
[3]Department of Psychiatry, Hanyang University Seoul, Guri, South Korea
[4]Department of Psychiatry, Hanyang University Seoul, Gyeonggi, South Korea

The SCL-90 is a commonly used 90-item self-report symptom inventory. Using items on the SCL-90-R, the 28-item scale was derived that discriminated between crime victims with and without PTSD. This scale named , but is now also referred to as the CR-PTSD Scale (Crime Related). Authors studied data from 104 PTSD patients and 265 other psychiatric patients. One week interval test-retest reliability and Cronbach alpha for internal consistency were calculated. SCL-PTSD proved moderate reliability and modest validity. Authors found moderate test-retest reliability for one week interval and high internal consistency (Cronbach alpha =.94). Convergent validity and concurrent validity was confirmed. Finally SUDS did not correlate with demographic factors demonstrating its discriminant validity. Given the lack of conceptual model or agreement on construct of SCL-PTSD, findings from this study should be carefully accepted especially concerning statistically significant but only modest validity. However, this exploratory study suggests that SCL-PTSD in PTSD patients has sound psychometric properties and that further investigation on its construct and clinical meaning would be necessary.

The Posttraumatic Growth Inventory: A Cross-Validation Study

(Abstract #196344)

Poster # F-203 (Assess Dx, Disaster) **Exhibition Hall, 4th Floor**

Osei-Bonsu, Princess E., MA[1]; Weaver, Terri L., PhD[1]; Maglione, Melissa L., MS[1]

[1]Psychology, Saint Louis University, Saint Louis, Missouri, USA

The original Posttraumatic Growth Inventory (PTGI) contains five factors- Relating to Others, New Possibilities, Personal Strength, Spiritual Change, and Appreciation of Life. This structure may not satisfy the theory of domain sampling. Most notably, two factors have very few items (Spiritual Change and Appreciation of Life have just 2 and 3 items respectively). It is possible that these factors are not individual constructs but together form a larger construct. Research suggests that posttraumatic growth does not have a 5-component structure but rather a 1- or 2-component structure. However, the samples used in these studies were dissimilar to the original 1996 study which used an undergraduate population. The proposed study will re-examine the component structure of the PTGI using an undergraduate student population (N = 200) from a large Midwestern university who have experienced a *DSM-IV* Criterion A-level traumatic event.

Aggression and Forgiveness Among Male Veterans With Chronic PTSD

(Abstract #196346)

Poster # F-204 (Practice, Clin Res) **Exhibition Hall, 4th Floor**

Didion, Lea, MA[1]; Burgoyne, Marissa, MA[1]; Casas, Elizabeth, MA[1]; Schutz, Kerri, MA[1]; Drescher, Kent, PhD[2]; Foy, David, PhD[3]

[1]Graduate School of Education and Psychology, Pepperdine University, Los Angeles, California, USA
[2]Department of Veterans Affairs, VA Palo Alto Health Care System, National Center for PTSD, Menlo Park, California, USA
[3]Pepperdine University, Encino, California, USA

Studies suggest that veterans with PTSD are more prone to violence and aggression as compared to veterans without PTSD (Castillo et al., 2002). The use of spiritual practices in the treatment of veterans is correlated with decreased anger (Benda, 2004), yet there is a paucity of empirical studies on which aspects of spirituality contribute to this inverse relationship. Interventions utilizing one dimension of spirituality, forgiveness, reduced levels of anger in men suffering from loss as compared to controls (Coyle & Enright, 1997). However, to date, there are no studies examining the relationship between forgiveness and aggression in veterans with PTSD. Data will be presented on 472 male veterans in residential treatment for PTSD who completed self-report measures of forgiveness of self, others, and from God and aggressive acts committed in the 4 months prior to entering treatment. Sample was 57% Caucasian with a mean age of 51. Significant differences were found between aggressive and non-aggressive veterans on the measure of forgiveness with non-aggressive veterans endorsing higher degrees of forgiveness. Among aggressive veterans, the number of aggressive acts endorsed and forgiveness were inversely correlated. Implications for incorporating forgiveness into clinical treatment are discussed.

Poster # F-205 (withdrawn)

Intimate Partner Violence, Maternal Posttraumatic Stress Disorder, and Parenting

(Abstract #196348)

Poster # F-206 (Child, Assess Dx) **Exhibition Hall, 4th Floor**

Burnett, Christiane, MA[1]; Hoffman, Casey, MA[1]; Samuelson, Kristin, PhD[1]

[1]California School of Professional Psychology at Alliant International University, San Francisco, California, USA

The deleterious effects of intimate partner violence (IPV) and PTSD on women's ability to parent is well recognized by clinicians, but not often studied empirically. Mothers with PTSD, who experience problems with feelings of disconnection and affect regulation, may have particular difficulties attending to the emotional needs of their children. When relationships between maternal PTSD and parenting have been studied, researchers have primarily utilized self-reports of parenting. This can be problematic, given that some researchers question the validity of parental self-report data, because parents may not be candid around negative parenting behaviors. The present study used both mother and child reports of parenting behaviors in a non-shelter sample of 42 children and their mothers, who have IPV histories. Severity of PTSD symptoms, as measured by the CAPS, was not related to maternal self-report of parenting, but was related to child report of negative parenting behaviors such as yelling, physical punishment, and ignoring, on the Parent Perception Inventory (r=.327, p=.034). These findings lend empirical support to the notion that parenting is impacted by PTSD and highlight the need for other-report measures of parenting, as maternal reports may be biased.

Poster # F-207 (withdrawn)

Preschool Classroom Intervention Strategies for Young Children Exposed to Violence

(Abstract #196352)

Poster # F-208 (Child, Clin Res) **Exhibition Hall, 4th Floor**

Black-Pond, Connie, MA[1]; Kiracofe, Love, MSW[1]; Henry, James, PhD[2]

[1]Unified Clinics, Western Michigan University, Kalamazoo, Michigan, USA

[2]Social Work, Western Michigan University, Kalamazoo, Michigan, USA

Young children exposed to violence are at high risk for multiple neurodevelopmental deficits (Henry, Sloane, Black-Pond, in press) including relational, behavioral and academic difficulties (Schore, 2001, 2003). Exposure to violence increases the risk of chronic stress responses that often result in over-development of regions of the brain responsible for anxiety (Schore, 1997). Children's survival/stress responses may be seen as "willfully disobedient" or labeled as mental health disorders that do not address the core developmental needs of children exposed to violence. Caregivers and staff in a preschool setting may become quickly overwhelmed with the challenges presented by a child's stress reactions. This session will focus on a preschool curriculum (funded through the Office of Juvenile Justice Safe Start Initiative) designed to increase social/emotional and academic competence for children exposed to violence. Professional development and parenting education strategies which mirror the curriculum will also be presented. The curriculum has a focus on five core elements that research indicates are necessary for successful outcomes in children exposed to violence: 1) Feeling Safe, 2) Relationships, 3) Calming Mind and Body, 4) Feeling Good about Learning, 4) Making Meaning of Experiences.

Resolving Early Memories Reduces the Distress of Later Related Memories

(Abstract #196353)

Poster # F-209 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Greenwald, Ricky, PsyD[1]

[1]Child Trauma Institute, Greenfield, Massachusetts, USA

Trauma therapists must make clinical judgments about which upsetting memories to target in what order, taking into account the particular client's ability to tolerate a potentially challenging trauma-focused session. This paper presents the results of a study with 119 participants in 10 trauma workshops (either EMDR or Progressive Counting, an exposure variant) in 4 countries. Participants first provided a SUDS rating of an identified distressing memory, then "floated back" and worked on an earlier memory, and finally provided another SUDS rating on the initial (not worked-on) identified memory. The final SUDS rating was lower for almost every participant, often substantially so, indicating that work on earlier related memories is likely to reduce the distress associated with a later memory. Follow-up with a subset of participants at 1 and 4 weeks post-treatment indicated some deterioration but substantial maintenance of effect. When the client's affect tolerance is a potentially limiting factor in proceeding with trauma work, the present findings support the strategy of first working through earlier related memories.

State Effect of Traumatic Experience on Personality Structure

(Abstract #196354)

Poster # F-210 (Child, Assess Dx) **Exhibition Hall, 4th Floor**

Son, Bong-Ki, MD, PhD[1]; Lee, Hong-Seock, MD, PhD[2]; Lee, Sang-Kyu, MD, PhD[3]

[1]Psychiatry, Hallym University Medical Center, Chuncheon, South Korea

[2]Psychiatry, Hallym University Medical Center, Seoul, South Korea

[3]Psychiatry, Hallym University Medical Center, Chuncheon, Kang-Won Do, South Korea

Background: Whatever personality may be, it has the properties of an open system, which is able to be reorganized by the experiences from environment.

Method: We compared the exploratory factor structure of the TCI's 25 primary subscales in the traumatized Korean adolescents (N=71) with that of the controls (N=296) by means of principal-components analysis and Promax rotation.

Results: In the control group, evaluation of the scree plot suggested a five-factor solution, accounting for 54.0 % of the total variance and each of the five factors explained 19.2%, 11.5%, 9.9%, 7.4%, and 5.9%, respectively. for the traumatized sample, on the contrary, a 3-factor solution accounted for 67.8% of the total percentage of variance that emerged and the rotated components accounted for 51.5%, 9.6%, and 6.7%, respectively. The Pearson intercorrelations between all of the TCI scales of the traumatized group were quite a bit higher than the corresponding correlations in the control group, and all seven scales were highly intercorrelated with each other.

Conclusion: Personality systems were reorganized into the triadic structure from the seven-factor structure as a response to trauma. The variability of personality structure across different situations, which has been known as the personality paradox, might not be simply random fluctuations.

How Dissociative Experience Scale Help in Planning Treatment in Patients With PTSD?

(Abstract #196356)

Poster # F-211 (Assess Dx, Media) **Exhibition Hall, 4th Floor**

St-Andre, Elise, FRCS(C)[1]

[1]Psychiatry, Universite de Montreal, Boucherville, Quebec, Canada

For EMDR trained therapists under supervision, Dissociative Experiences Scale is a tool strongly suggested in the assessment an treatment planning of patients suffering of traumatics symptoms, such as PTSD. It is also suggested to newly EMDR trained therapists, to refer the patient to a more specialised trained specialist in PTSD, if the score of this scale should be over 25. However, in some cases, the EMDR therapist is already in good alliance with the patient, or get some experiences-or is willing to learn more about dissociatives symptoms. How the Dissociatives Experiences Scales score can then help in the treatment decision planning to help the patient? Should we start with some repeted "soft" procedures such as Safe Place Imagery? Ressources installation imagery? Should we repeat the scale? If so, what is the appropriate time? What is the meaning of a different score? More importantly, what are correct way to fill this scale? and how a patient is reacting to such process? Is this observation mean anything about PTSD severity of symptoms? With the help of clinical cases, we will offer some tentatives answers to those questions.

Participant Alert: The Dissociative Experiences Scale describes very well some symptoms that patients may have experienced.

The Role of Trait Anger in Predicting Dysfunctional Sexual Behavior After Interpersonal Trauma

(Abstract #196357)

Poster # F-212 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Blain, Leah, BA[1]; Walsh, Ryan, MA[1]; Galovski, Tara, PhD[1]

[1]Center for Trauma Recovery, University of Missouri-St. Louis, St. Louis, Missouri, USA

Many survivors of interpersonal trauma experience increases in dysfunctional sexual behavior (DSB; Bartoi & Kinder, 1998), which can lead to a number of negative outcomes (Koenig, Doll, O'Leary, & Pequegnat, 2004). The current study assessed the relationship of trait anger to DSB. Given the strong relationship of depression to DSB (Green et al., 2005), depression severity was controlled for in the present model. for this study, analyses were conducted on a small sample of 12 initial participants from part of a larger, NIMH-funded grant evaluating Cognitive Processing Therapy effectiveness. Participants completed the Beck Depression Inventory-II, the State-Trait Anger Expression Inventory, and the Trauma Symptom Inventory. Multiple regression analysis revealed that trait anger significantly predicted DSB, after controlling for depression ($F= 4.13$, $p< .05$). The overall model had a medium effect size (adjusted $R2= .36$), and both depression and trait anger had significant beta weights ((depression)= -.896, $p< .05$ ((anger)= .823, $p< .05$). These findings indicate that anger may play an important role in predicting DSB, and may be an important risk factor for those with a history of interpersonal trauma. We expect to have a sample 40 individuals by November 2008, and an even stronger relationship is anticipated with more data.

Progressive Counting for Trauma Resolution

(Abstract #196361)

Poster # F-213 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Greenwald, Ricky, PsyD[1]; Greenwald, Hanneli, NA[1]

[1]Child Trauma Institute, Greenfield, Massachusetts, USA

Progressive Counting (PC) is a relatively simple new trauma resolution procedure based on the Counting Method (an exposure variant) and modified for enhanced efficiency and client acceptability. Pre/post data on over 200 workshop participants in 4 countries indicates good client tolerance and rapid treatment effects. Case reports have also been promising; controlled research is underway. Participants in this workshop will gain an overview of PC's empirical basis and possible mechanisms of effect, and have an opportunity to experience PC with a minor upsetting memory.

Personal Narratives of Terror, Surviving, and Maintaining Hope

(Abstract #196362)

Poster # F-214 (Civil Ref, Cul Div) **Exhibition Hall, 4th Floor**

Boskailo, Esad, MD[1]; Songasonga, Martine, MA[2]; Ibeagha, Anthony, MA[3]

[1]Maricopa Integrated Health System, Mesa, Arizona, USA
[2]Heartland Alliance, Chicago, Illinois, USA
[3]Torture Abolition and Survivor Support Coalition, Chicago, Illinois, USA

Torture survivors learn to live with the long-term consequences of the terror they endured. This presentation shares personal narratives of trauma across the lifespan of the individual and across generations. Their stories teach us about terror and resilience and offers insights on maintaining hope in times of despair.

Effects of Political Terror on the Stages of My Life
As a human rights advocate in the Democratic Republic of Congo, my life became a target for persecution, violence and fear. I was forced to seek asylum in the United States. Being forced into exile is an act of terror in itself. It is a difficult life, and is a continuation of the trauma suffered. I am cut off from the lifeline of my family, from my human rights activities, my friends, my belongings, and everything familiar. While trying to adjust to life in the United States, where the culture, language, laws and regulation are different from my home country, the war raging in my country placed my remaining family in a dangerous situation. Hence, the remainder of my family was also forced into exile for political reasons, but fled to neighboring countries. My mother fled to South Africa after experiencing violence and is now ill. As her daughter, I am unable to assist her in providing the care she needs. This presentation will discuss the impact of terror on my family and our struggle to maintain hope in the face of despair.

After Three Decades of Terror: What is Left?
Born into a war and becoming a constantly fleeing refugee from infancy to adulthood, the way I think, act and evaluate other human beings are deeply determined by how I deal with terror. Having been through torture at three different occasions in my life separated by too few years of calm, torture and terror have defined my very existence in terms of fear, doubt and suspicion of everything and everyone. This has led me to live in a state of internal psychological confusion and conflict. When I have had the ability to trust, it has been a cautious trust. When I have had to make decisions, I have had to approach them from a point of economic weakness, social insecurity, political silence, lack of self-esteem, discrimination, loneliness and an ever present psychological agony-my memories. I cannot afford to make mistakes any longer; I am forced to accept the fact that I am living the "leftovers" of the life I would have lived had I not been tortured. This presentation is a personal narrative of torture, survival, and hope over three decades.

Transgenerational Experiences of Terror: Collective Wisdom
My grandfather spent four years interned in an Italian concentration camp during WWI. I learned from his ability to find a positive aspect in his experiences. By learning Italian, he became an interpreter for the Italian Army during WWII, obtaining extra food for family. He said, "If I was not in a concentration camp in WWI, we would die from hunger in WWII." Detained during the Bosnian War, I thought, "If my grandfather survived four years I can do at least two. I have to keep family tradition going." While interned, I found an English dictionary to study. Resettled in the United States, I worked as an interpreter assisting Bosnian refugees. It was difficult to learn my two sons were held in a camp with their mother, however, I also learned from them. When distressed by memories, I made generalized statements against the people who held me. My sons said, "Dad, not all of them are bad." The collective wisdom of my family makes me stronger. In my current work as a psychiatrist I integrate these lessons into my practice. My grandfather's message of finding meaning after terror assists me in helping survivors find purpose in their altered life roles.

Comorbity Between PTSD (N=1368) and Personality Disorders in a Nationally Representative Sample

(Abstract #196363)

Poster # F-215 (Assess Dx, Clin Res) **Exhibition Hall, 4th Floor**

Gupta, Madhulika, MD[1]

[1]University of Western Ontario, London, Ontario, Canada

Backgrounds: Symptoms of PTSD may fulfill the diagnostic criteria for a wide range of personality disorders. We examined the comorbidity between PTSD and personality disorders, diagnosed using ICD9-CM criteria, in a nationally representative sample (N=1368, 67% female), representing an estimated 11 million patient visits for PTSD.

Methods: Data collected from 1995 to 2003 by the National Ambulatory Medical Care Survey and National Hospital Ambulatory Care Survey , which are surveys conducted by the National Center for Health Statistics, were examined.

Results: The overall odds ratio (OR) (95% CI) for a diagnosis of any Personality Disorder (ICD9-CM code 301) was 20.10 (13.20-30.60). The following are the specific personality disorders with significant ORs (95%CI): Paranoid: OR=22.43 (3.65-137.94); Schizoid: OR= 39.12 (5.33-287.24); Cyclothymic: OR=30.93 (10.10-94.77); Explosive: OR=44.24 (18.20-107.52); Histrionic: OR=11.85 (2.35-59.78); Borderline: OR=19.15 (10.50 -34.92); Antisocial: OR=18.0 (2.67-121.33); Compulsive: OR=44.24 (18.20-107.52); and, Dependent: OR=29.14 (11.86-71.62).

Comment: PTSD was comorbid with all major groups of Personality Disorders in a nationally representative sample, with most commonly associated personality disorder types generally representing the 'Cluster B' group in the *DSM IV*.

Psychosocial Impact of Burn Injuries on Young Children and Families

(Abstract #196364)

Poster # F-216 (Child, Assess Dx) **Exhibition Hall, 4th Floor**

De Young, Alexandra, BPSYSC[1]; Kenardy, Justin, B.SC, PhD[2]; Cobham, Vanessa, BA, PhD[2]; Kimble, Roy, MD[3]; Keogh, Samantha, PhD[3]

[1]Centre of National Research on Disability and Rehabilitation Medicine, University of Queensland, Brisbane, Queensland, Australia
[2]University of Queensland, Brisbane, Queensland, Australia
[3]Royal Children's Hospital, Brisbane, Queensland, Australia

Due to the challenges of conceptualising and assessing psychopathology in young children there is still much to be learnt about the validity, prevalence and course of emotional and behavioural disorders following trauma in this age group. Paediatric burns are one of the leading causes of hospitalisation in Australia with approximately 70% of burns occurring in children under the age of five. Burns are particularly devastating as they have the potential to be an ongoing source of traumatic stress long after the initial event. However, little is known about the immediate and long-term impact burns have on young children's social, emotional and behavioural development. Therefore this exploratory study aims to investigate the psychosocial impact of burn injuries on young children and their families. One hundred unintentionally burned children (1-6 years) and their parents were recruited from a specialist burns centre in Australia. Diagnostic interviews were conducted with parents about their child's psychological and behavioural adjustment at one and six months post injury and a battery of parent report questionnaires were also completed. This presentation will focus on the challenges of assessment and diagnosis of psychopathology, particularly PTSD, in young children; prevalence of traumatic stress reactions in this population and treatment recommendations.

Childhood Trauma History in Nonclinical Dissociators With and Without Recovered Memory Experiences

(Abstract #196365)

Poster # F-217 (Assess Dx, Practice) **Exhibition Hall, 4th Floor**

Chiu, Chui-De, MS[1]; Yeh, Yei-Yu, PhD[2]; Wu, Yin-Chang, PhD[2]

[1]National Taiwan University, Taipei, Taiwan
[2]Psychology, National Taiwan University, Taipei, Taiwan

In our previous study, nonclinical dissociators showed more RME, defined as whether they ever suddenly recollect experience they had never known of its occurrence. Moreover, these memories are not predominantly relevant to aversive events. This result implies that RME might be non-specific autobiographical memory lapses in dissociators. Nevertheless, the link between RME and CTH is unclear. We investigated CTH in the original sample from which we examined RME, as early trauma could be a risk factor for abnormal development of neural substrates involving in memory functions. The results showed that generally the dissociators with RME did not report more CTH than the dissociators without RME, but both reported more CTH than the nondissociators. However, there was a trend that the dissociators with RME scored higher on some abuse subscales, comparing with the dissociators without RME. These results will be elaborated in Pierre Janet's theory on trauma and dissociation.

Differential Response to Specialized Inpatient Trauma Treatment Based on Symptom Level at Admission

(Abstract #196366)

Poster # F-218 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Rosenkranz, Susan, MA[1]; Muller, Robert, PhD[1]; Bedi, Ritu, MA[1]

[1]Department of Psychology, York University, Toronto, Ontario, Canada

The current health care spending climate in North America is precipitating the closure of specialized inpatient trauma treatment programs. As such, it is important to investigate whether there are patients who may experience distinct benefit from these programs, to determine whether inpatient trauma treatment is an important option to maintain despite arguments that more cost-effective approaches may produce similar outcomes. The purpose of the current study was to examine whether the efficacy of one such program varied by level of symptoms reported by patients at admission. Participants (N = 115) entering an inpatient trauma treatment program in Ontario, Canada completed self-report measures of their trauma symptoms at waitlist, admission, discharge, and 6-months post-discharge. Results indicated that the treatment group's trauma symptoms reduced significantly in comparison to the waitlist group, and this reduction was maintained following treatment. The treatment group was then divided into those whose symptom levels at admission were low, intermediate, and high. Results indicated that patients with intermediate and high symptom levels experienced significant symptom reductions over treatment; however, only those with an intermediate level maintained treatment gains following discharge. Implications for inpatient trauma treatment programs will be discussed.

Forgiveness & Depression in Veterans With Chronic Combat-Related PTSD

(Abstract #195994)

Poster # F-219 (Practice, Clin Res) **Exhibition Hall, 4th Floor**

Jakle, Katy, MA[1]; Metz, Sarah, MS[1]; Lovato, Lauren, MA[1]; Kelly, Carrie, MA[1]; Drescher, Kent, PhD[2]; Foy, David, PhD[3]

[1]Pepperdine University, Los Angeles, California, USA
[2]NCPTSD-VAMC Palo Alto, Palo Alto, California, USA
[3]Pepperdine University, Encino, California, USA

Limited empirical research has examined the relationship between forgiveness and depression in veterans with PTSD. One study found an inverse relationship between these variables (Witvliet et al., 2004). Our archival study replicates this previously identified relationship between forgiveness and depression in PTSD veterans using a larger sample, an inpatient population, and a measure of spirituality that includes not only forgiveness of self and others, but also forgiveness by God. 472 male veterans completed questionnaires upon entrance to residential PTSD treatment, including the BDI and the 3-item forgiveness Scale of the BMMRS (Fetzer Institute, 1999). The sample was 57% Caucasian with an average age of 51 years (SD=10.3). Descriptive statistics will be reported for all study variables. Results indicate a significant inverse relationship between all three forgiveness items and the BDI total ($p<.0001$), as well as the forgiveness index score and the BDI total. Multivariate regression analyses indicate that forgiving oneself and forgiving others are most associated with the decrease in depression scores. Implications for integrating forgiveness into PTSD residential treatment programs are discussed.

Correlates for Legal Helpseeking: Risk and Resilience Factors for Battered Women in Shelter

(Abstract #200454)

Poster # F-220 (Practice, Clin Res) **Exhibition Hall, 4th Floor**

Wright, C. Vaile, PhD[1]; Johnson, Dawn, PhD[1]

[1]Summa-Kent State Center for the Treatment and Study of Traumatic Stress, Akron, Ohio, USA

Legal redress plays a critical role in interrupting the pattern of domination and control inherent in intimate partner violence(IPV) situations, yet it remains an infrequent strategy among battered women. Past research examining the reasons why battered women engage in certain legal helpseeking behavior, such as calling the police or filing for a civil protection order, has examined helpseeking behavior as a one-time event. Further, researchers have generally focused on either situational aspects of the abuse or certain individual characteristics of the women themselves in explaining criminal justice engagement. The current study employed a multifactor sociocultural framework for investigating the correlates for engagement in the criminal justice system for a sample of 227 sheltered battered women. Results indicated that individual, relational, and system-level factors were all associated with three legal helpseeking behaviors:calling police, having a civil protection order, and criminal prosecution. In particular, this study found PTSD symptomology, relationship length, social support, and prior experience with the criminal justice system to be significant risk and resilience factors for legal helpseeking. Results highlight the need for a coordinated community response to intimate partner violence, addressing both legal needs and psychological needs simultaneously.

Risk and Resiliency in the Context of Revictimization Following Domestic Violence

(Abstract #200456)

Poster # F-221 (Practice, Clin Res) **Exhibition Hall, 4th Floor**

Walter, Kristen, MA[1]; Johnson, Dawn, PhD [2]

[1]Kent State Univeristy, Akron, Ohio, USA

[2]Summa-Kent State Center for the Treatment and Study of Traumatic Stress, Akron, Ohio, USA

Revictimization has emerged as an important area in the trauma literature. Studies suggest that revictimization leads to various negative outcomes, as compared to individuals exposed to one traumatic event or non-traumatized individuals including greater levels of PTSD. PTSD has also been proposed as a mediator of the relationship between prior traumatic experience and subsequent revictimization. Determining predictors, mediators and outcomes of revictimization will inform interventions and treatment. The current study explored revictimization with regard to risk and resiliency factors in an ongoing prospective study of women temporarily residing in a shelter following domestic violence. In preliminary analyses with 98 women who experienced domestic violence in the month prior to shelter admittance, Ninety-eight percent of the sample was revictimized by either domestic violence or experienced other traumatic events over the course of the study. Results revealed that revictimization positively predicted the risk factor of PTSD symptoms and negatively predicted the resiliency factor of resource gain at 6 month follow-up. Furthermore, these risk and resiliency factors at baseline predicted subsequent revictimization at follow-up. Risk factors, resiliency factors and potential mediators will be discussed in the context of revictimization related to domestic violence.

Treating Battered Women to Reduce Risk and Promote Resilience

(Abstract #200458)

Poster # F-222 (Practice, Clin Res) **Exhibition Hall, 4th Floor**

Johnson, Dawn, PhD[1]

[1]Summa-Kent State Center for the Treatment and Study of Traumatic Stress, Akron, Ohio, USA

Violence against women is a significant social problem, with as many as 22 to 29% of women reporting histories of physical abuse by intimate partners. Research suggests PTSD is associated with significant loss of resources and an increased risk for revictimization. Despite the high rates of PTSD found in battered women, virtually no treatments for these women have been developed or tested. This presentation will provide results from randomized control trial (N = 70) evaluating the initial efficacy a new treatment for battered women in shelters, Helping to Overcome PTSD through Empowerment (HOPE). HOPE is a first-stage cognitive-behavioral treatment that emphasizes safety, self-care and protection, empowerment, and education and training in skills to help cope with PTSD. Issues in implementing a treatment program for battered women in shelters will be discussed. Preliminary results suggest that battered women who receive HOPE report significant gains when compared to those who do not receive HOPE. Women who completed HOPE display less severe PTSD symptoms, less resource loss, less depression, greater social support, and less re-victimization one-week after leaving shelter. Further, these gains were maintained at 3-months post-shelter. Clinical implications, as well as implications for future research with HOPE will be presented.

Promoting Resilience in the Face of Risk

(Abstract #200500)

Poster # F-223 *(Practice, Clin Res)* **Exhibition Hall, 4th Floor**

Perez, Sara, MA[1]; Hobfoll, Stevan, PhD[1]; Johnson, Dawn, PhD[2]

[1]Kent State Univeristy, Akron, Ohio, USA

[2]Summa-Kent State Center for the Treatment and Study of Traumatic Stress, Akron, Ohio, USA

The relationship between intimate partner violence (IPV) and posttraumatic stress disorder has been well established but the mechanisms underlying this relationship remain unclear. To further our understanding of potential risk and resiliency factors in the relationship between IPV and PTSD, the current study sets out to delineate the role of resources, empowerment, and their multiplicative effects as potential mediators between IPV and PTSD. It is hypothesized that both resource loss and empowerment will mediate the relationship between IPV and PTSD. Further, it is hypothesized that the interaction of resource loss and empowerment will serve to further mediate the relationship between IPV and PTSD. Using both a shelter and community sample of female victims of intimate partner violence, participants completed a baseline and one month follow-up interview assessing severity of IPV, resource loss, empowerment, and PTSD symptom severity. The results of hierarchical multiple linear regressions suggest that the change in overall levels of both resource loss and empowerment over a one-month follow-up serve as risk and resiliency factors in recovery from PTSD related to intimate partner violence. The need for those working with this vulnerable population to help promote resiliency in the face of risk factors will be discussed.

Session 3: Saturday November 15
Exhibition Hall, 4th Floor

Poster Organization

Each poster is scheduled for either Poster Session 1 on Thursday, Poster Session 2 on Friday or Poster Session 3 on Saturday. Each session includes a one-hour time period where the presenting author is available to answer questions.

Posters are organized within the final program by presentation day. The presenting author is underlined. In addition, the index provided at the rear of the final program includes all of the authors. A floor map showing the layout of posters is available in the poster hall and is available on page 160.

Session 3: Saturday, November 15
Exhibition Hall, 4th Floor

Poster Set-Up:	7:30 a.m. – 9:30 a.m.
Poster Display:	9:30 a.m. – 6:00 p.m.
Poster Presentation:	5:00 p.m. – 6:00 p.m.
Poster Dismantle:	6:00 p.m.

Poster Dismantle

Immediately following your scheduled poster session, display materials must be taken down and removed. Items not removed by the appointed poster dismantle time **will be disposed** of and are not the responsibility of ISTSS.

Tracks

Posters will be presented on a wide variety of topics indicated by track:

1. Assessment/Diagnosis (Assess Dx)
2. Biological/Medical (Bio Med)
3. Children and Adolescents (Child)
4. Civilians in War/Refugees (Civil Ref)
5. Clinical or Interventions Research (Clin Res)
6. Clinical Practice Issues (Practice)
7. Community Programs (Commun)
8. Culture/Diversity (Cul Div)
9. Disaster/Mass Trauma (Disaster)
10. Media/Training/Education (Media Ed)
11. Military/Emergency Services/Aid workers (Mil Emer)
12. Prevention/Early Intervention (Prev EI)
13. Research Methodology (Res Meth)
14. Social Issues/Public Policy/Ethics (Soc Ethic)

Life Stressors and Posttraumatic Symptoms in Juvenile Offenders: Implications for Developmental Trauma Disorder

(Abstract #196369)

Poster # S-101 (Child, Assess Dx) **Exhibition Hall, 4th Floor**

McClintic, Brook, PhD[1]; Silvern, Louise, PhD[2]; Schulz-Heik, Jay, MA[2]; Stolbach, Bradley C., PhD[3]

[1]Judi's House Bereavement Center, Denver, Colorado, USA
[2]University of Colorado, Boulder, Colorado, USA
[3]Chicago Child Trauma Center, La Rabida Children's Hospital, Chicago, Illinois, USA

This study tested predictions derived from the concepts of Developmental Trauma Disorder (DTD) and simple PTSD. Participants were 138 recidivist, male adolescent criminal offenders; all had non-violent offenses and 79 had violent offenses. Four data sources about maltreatment and other childhood stressors were utilized, as were criminal records and measures of symptoms and anti-social attitudes. Over 80% of subjects had maltreatment histories. Consistent with both diagnoses, elevated PTSD symptoms were associated with acutely frightening PTSD Criterion A maltreatment (i.e., physical and sexual abuse and domestic violence.) DTD suggests that additional stressors that do not meet Criterion A, but disrupt child-parent attachment, (e.g., neglect, psychological abuse) induce PTSD and various other symptoms, including dissociation and violence. Numerous findings were consistent with DTD. For example, psychological abuse predicted elevated PTSD symptoms, and Criterion A maltreatment and psychological abuse predicted dissociation. DV and certain other stressors predicted violent versus only non-violent crimes; PTSD symptoms (not anti-social attitudes) were significantly higher among violent offenders. Neglect, however, predicted no symptoms. DTD improves upon PTSD in accounting for the high rate of childhood stressors and diverse associated symptoms in these externalizing youth.

Responding to Immediate and Long-Term Consequences of Terror

(Abstract #196372)

Poster # S-102 (Civil Ref, Cul Div) **Exhibition Hall, 4th Floor**

Fabri, Mary, PsyD[1]; Gray, Amber, MPH, MA[2]; Uwineza, Jeannette, BA[3]

[1]Marjorie Kovler Center, Chicago, Illinois, USA
[2]Restorative Resources, Santa Fe, New Mexico, USA
[3]Women's Equity in Access to Care & Treatment, Kigali, Rwanda

Terror has profound immediate and long-lasting impact on human lives and communities. This presentation will describe work being done to support humanitarian workers remaining in Darfur, the development of a torture treatment center in northern Iraq, and the response to the emerging problem of sexual abuse of children in Rwanda.

Responding to the Training Needs of Providers in Iraq
The United Nations High Commissioner for Refugees (UNHCR) estimates more than 4.2 million Iraqis have left their homes. 2.2 million are internally displaced and close to one million are living in northern Iraq. In a study conducted by UNHCR, one in five Iraqi's is a victim of violence or torture. A study with refugees in Syria found 89% had symptoms of depression and 82%, anxiety. With these staggering numbers, the State Department's Bureau of Populations, Refugees and Migration has funded the development of a torture treatment and training center in northern Iraq. This presentation will describe the identification, training, and supervision of Iraqi staff that will be responsible for improving the quality and access to specialized treatment for adult victims of torture and other human rights violations in Iraq by establishing the Center for the Trauma Rehabilitation and Training in Suleymaniya. The trainings include assessing and improving the clinical and management skills of physicians, social workers, and psychiatrists in the treatment of traumatic stress in adults and their families. This presentation will describe and discuss the development of training needs and their implementation with a focus on cultural adaptation for the Iraqi experience.

In the Wake of Terror: Managing Staff Stress in Darfur
The Darfur crisis reports some of the worst human rights abuses imaginable, including systematic and widespread abduction, murder, and rape. Over 2 million people are displaced, and it is estimated over 200,000 people have been killed. The ongoing terror Darfurians and humanitarian workers are exposed to almost daily contribute to elevated stress levels. Aid workers are targets in the ongoing violence. Exposure to shooting, killing and human atrocity is common. This presentation describes the development of a comprehensive staff support program, tailored for the largest nongovernmental organization (NGO) operating in West Darfur. While many NGO's have withdrawn from the region, those remaining continue to provide crucial support to internally displaced persons at great personal risk to both expatriate and national staff. Staff stress level assessments, psychological first aid, strategies for individual and organizational stress management, wellness practice, critical incident response,

reflective listening and supervision, and team support and cohesion are all components of the agency-wide program. This presentation will describe a contextual background for the work, assessment strategies, cross cultural adaptations of the instruments and interventions, resources used and developed, and recommendations for organizational staff support in complex humanitarian crises.

Child Sexual Abuse in Post-conflict Societies: A Rwandan Example
Rwandan National Police report sexual abuse of children the most frequently committed crime in post-genocide Rwanda. Development of a protocol to assess the needs of the children is imperative. The Kigali based Family Program of Women's Equity in Access to Care and Treatment (WE-ACTx) developed an evaluation strategy to identify child victims of sexual abuse. The WE-ACTx treatment team is comprised of Rwandan physicians, nurses, trauma counselors and a psychologist. The trauma counselors identify children in the program with poor self-esteem, high risk behaviors, and inappropriate sexual conduct. Medical personnel evaluated somatic complaints such as headaches, trouble sleeping, and genital pain. Identified cases were referred to the psychologist for evaluation and treatment recommendations. This presentation will describe the implementation of this model with fifteen adolescents. The team observed a qualitative reduction of symptoms. All fifteen girls demonstrated improved peer relationships and self-esteem. Several who had stopped attending school elected to return. Cultural taboos that handicap therapeutic intervention will also be discussed. Recommendations to promote coordinated efforts for the protection of the child in Rwanda and other post-conflict societies will also be offered.

How Will We Know Things Are Getting Better? A Logic Model for Veteran Mental Healthcare

(Abstract #196373)

Poster # S-103 (Ethics, Res Meth) **Exhibition Hall, 4th Floor**

Lewis, Virginia, PhD[1]
[1]*University of Melbourne, Melbourne, Victoria, Australia*

Governments build policy and implement change around strategic objectives and goals. The assumptions underlying strategies are often unstated. Despite this there is an implicit underlying logic that links all initiatives - from broad service and system development activities to specific targeted projects - to the strategic goals. While there is a growing interest in evidence-based policy, particularly through what is termed "knowledge translation", governments need to have a strong understanding of the logic underlying broad strategic policy in order to use evidence effectively.

One of the agreed goals for the (Australian) Department of Veterans' Affairs is to improve the mental health and wellbeing of veterans. This paper describes a logic model that represents the links between the strategic policy projects and their intended impacts and outcomes for veterans. The paper describes how this model operates as a framework for research, evaluation and monitoring of the mental health system. A logic model framework supports collection of appropriate targeted data and interpretation of secondary data in a cohesive and coherent manner that supports policy and service development.

Challenges in Developing a Mental Health Evaluation Program for Refugees

(Abstract #196377)

Poster # S-104 (Civil Ref, Clin Res) **Exhibition Hall, 4th Floor**

Laugharne, Jonathan, MBBS[1]**; Ventouras, Jane, BA**[1]**; Janca, Aleksander, MD**[2]
[1]*University of Western Australia, Fremantle, Western Australia, Australia*
[2]*University of Western Australia, Perth, Western Australia, Australia*

This presentation addresses the experiences of the authors in developing and implementing a program of mental health evaluation in refugee migrants recently arrived in Western Australia. The program aims to evaluate 200 adult refugees using the Kessler 10 and the WHO PTSD Screener. Participants screening positive will be offered further evaluation with the PTSD, depression and anxiety modules of the CIDI. Aims are to establish prevalence rates for these disorders within this population and to identify any relationships between demographic factors, country of origin or trauma history and current psychopathology. Issues in developing the project to the point of initial implementation have included difficulties in identifying the optimal point of contact within current refugee services for integrating the screening process, overcoming language barriers when multiple languages are represented, instrument selection, and addressing concerns of other parties involved in existing health and social assessments of incoming refugees.Ethical considerations have included difficulties with obtaining valid consent in this population due to language and cultural barriers, ensuring adequate clinical follow-up when indicated, adequate interpreter skills to reduce risk of bias/misdiagnosis and ensuring that our assessment would have no implications for a participant's visa status.

Predicting PTSD, Quality of Life, and Disease Progression Among Cancer and HIV Survivors

(Abstract #196378)

Poster # S-105 (Bio Med,Prev EI) **Exhibition Hall, 4th Floor**

Park, Crystal, PhD[1]**; Mills, Mary Alice, MA**[2]**; Kissinger, Patricia, PhD**[3]**; Reilly, Kathleen, MPH**[4]**; Benight, Charles C., PhD**[5]**; Schmidt, Norine, MPH**[3]**; Curtin, Erin, MPH**[6]**; Luszczynska, Aleksandra, PhD**[7]
[1]*University of Connecticut, Storrs, Connecticut, USA*
[2]*Psychology, University of Connecticut, Storrs, Connecticut, USA*
[3]*Department of Epidemiology, Tulane University, New Orleans, Louisiana, USA*
[4]*Tulane University, New Orleans, Louisiana, USA*
[5]*University of Colorado at Colorado Springs, Colorado Springs, Colorado, USA*
[6]*Tulane University School of Public Health and Tropical Medicine, New Orleans, Louisiana, USA*
[7]*University of Colorado, Colorado Springs, Colorado, USA*

The poster discusses psychological processes explaining changes in PTSD and quality of life among survivors of health-related trauma. Our research indicated that prevention programs should address making meaning, support provision, and self-efficacy, which affect the development of PTSD or quality of life. Prevention of PTSD may reduce disease progression.

Meaning Making and Intrusions in Longer-Term Cancer Survivors
The experience of cancer is often a traumatic experience, even years later, yet little is known about the cognitive factors that lead to lingering PTSD symptomatology. In the present study, we tested the hypothesis that the extent to which longer-term survivors of various cancers continued to experience intrusions would be related to their appraised meanings of the cancer as well as their meaning-focused coping efforts. Participants were 158 younger adult cancer survivors (M time since treatment completion = 2.6 years; age = 18-50 (M = 45.2), 88% Caucasian, 68% women). Results indicated that most survivors experienced some intrusions; only 14% reported none, while 20% scored above a clinical cut-off

score on the IES-R intrusions subscale. Predictors of intrusions were appraising the cancer as violating their goals and their beliefs in the fairness of the world and one's views of self, medical staff, and God as being in control. Acceptance coping was also predictive of fewer intrusions, but religious coping, positive reappraisal and emotional processing were unrelated. These results suggest that perceived violations of one's global meaning are potent predictors of continued intrusions, but few meaning making coping strategies seem to lessen them, a partial confirmation of the meaning making model.

Psychological Effects on HIV Disease Progression Following Hurricane Katrina

In August 2005 Hurricane Katrina displaced approximately 8000 HIV-infected persons. The psychological effects on the disease progression of HIV-infected patients from this disaster is unknown. One year post-storm, we interviewed 145 patients who had attended the HIV Outpatient Program clinic prior to the storm. We gathered information on demographics and psychological measures, along with HIV-related laboratory results. Fifty-four (37.2%) patients had posttraumatic stress disorder (PTSD) one year after the storm. There was no significant difference in median CD4 before the hurricane for those who had PTSD (285) and those who did not have PTSD (374) (p=0.46). There were, however, significantly more CD4 for those with PTSD at one year (247 vs. 357 (p=0.003)) and 18 months after the hurricane (283 vs. 383 (p=0.01)). Likewise, median log-transformed HIV viral loads were not significantly different pre-storm (PTSD: 8.94, no PTSD: 5.99 (p=0.13)), but those with PTSD had higher viral loads both at one year (7.71 vs. 5.99 (p=0.03)), and 18 months (6.26 vs.5.99) (p=0.007). Those with HIV that develop PTSD after experiencing a traumatic event are more likely to progress in their HIV severity. Special assistance should be provided to HIV patients at the time of disasters to prevent deleterious psychological events and HIV progression.

Psychological Resources and Quality of Life Among HIV/ Cancer Survivors

The paper discusses findings from three studies investigating whether among people living with HIV and cancer survivors social support and self-efficacy may predict finding benefits, which in turn may be related to quality of life (QoL). Study 1, conducted among 104 patients living with HIV suggested that finding benefits and self-efficacy were directly related to adherence to medication and QoL. Finding benefits mediated the relation between social support and adherence or QoL. Using longitudinal design, Study 2, conducted among 50 dyads of cancer survivors and their partners confirmed that both perceived and provided social support predicted aspect of finding benefits among patients, whereas benefits predicted QoL. Benefit finding among partners and patients did not predict support provision or receipt measured at a follow-up. Data collected among 109 individuals over 1 year after cancer diagnosis (Study 3) indicated that controlling for disease characteristics self-efficacy remained the strongest predictor of an increase of most of QoL dimensions, whereas support receipt predicted changes in psychological dimensions of QoL. Concluding, the longitudinal studies confirm direct effects (size: medium) of self-efficacy and benefit finding and indirect effects of provision and receipt of social support on QoL.

Prevalence of Civilian Trauma and Posttraumatic Stress Disorder in the Population Sample of Kashmir

(Abstract #196379)

Poster # S-106 (Disaster, Cul Div) **Exhibition Hall, 4th Floor**

Margoob, Mushtaq, MD[1]; Mushtaq, Huda, MPHIL[1]

[1]Postgraduate Department of Psychiatry, Govt. Medical College, Srinagar, Kashmir, India

Kashmir has been witnessing a continuous mass trauma situation for more than past 18 years. A community based survey, assessing the prevalence of traumatic events and it's impact was undertaken by the first author and his team. Evaluation yielded a lifetime prevalence of traumatic events of 58.69%. The trauma exposure rates in males and females were similar(males = 59.51%,females = 57.39%).Among the vents experienced, firing and explosions, war zone trauma, death of a close person, physical assaults, life threatening injury or illness were among the commonest traumas experienced in a mass trauma situation in this part of the world. *DSM-IV* based MINI neuropsychiatric interview assessment yielded a current PTSD rate of 7.27% and lifetime PTSD rate of 15.19%. Importantly the rates in males and females were comparable. Because of the loss of social support network which chronic conflict is known to cause, many of the traumatized children land up in orphanages. Posttraumatic Stress Disorder was the commonest diagnosis present in 40.62% of the sample in one of our studies on children in orphanages in Kashmir, followed by Major Depressive Disorder (25%); Conversion Disorder in 12.5% ; panic disorder in 9.38%and Attention Deficit Hyperkinetic Disorder in 6.25%.

The Affective Diary: A New Digital Device as a Help for Coping With the Aftermath of Terror

(Abstract #196380)

Poster # S-107 (Child, Prev EI) **Exhibition Hall, 4th Floor**

Uttervall, Mats, PhD-Student[1]; Hultman, Christina, Associate Professor[2]; Svensson, Martin, PhD[3]; Hook, Kristina, Professor[4]

[1]Medical Epidemiology and Biostatistics, Karolinska Institutet, Stockholm, Sweden

[2]Dep Medical Epidemiology and Biostatistics, Karolinska Institutet, Stockholm, Sweden

[3]Interaction Laboratory, Swedish Institute of Computer Science, Kista, Sweden

[4]Interactive Institute, Swedish Institute of Computer Science, Kista, Sweden

A diary provides means to express inner thoughts, record experiences of past events and provides a resource for reflection. A digital diary that can record both notes, drawings, pictures, SMSs, blue tooth-presence and biosensor data provides a new possibility to document life from an affective point of view. The idea behind the design is embodied emotional experiences, where movement and arousal are presented as ambiguously shaped and colored characters mapped out along a timeline. The representation of the data can be played as a movie, thus reflecting the day. The user is involved in a creative process, with the possibility to reflect on personal problems from an affective perspective and also to document thoughts and feelings preparing for future treatment. The system also offers the possibility to identify those individuals who has the most urgent need for treatment. The evaluation-group is between 16 and 20 years old and experienced the tsunami-disaster in south-east Asia in 2004. The results suggest future usage by young people exposed to terror and war.

Posttraumatic Stress Disorder in Acute Myocardial Infarction Patients

(Abstract #196381)

Poster # S-108 (Res Meth, Clin Res) **Exhibition Hall, 4th Floor**

Oflaz, Serap, MD[1]; Yuksel, Sahika, MD[2]

[1]Psychiatry, Istanbul University, Istanbul Medical Faculty, Capa, Istanbul, Turkey

[2]Istanbul Univ Sch of Psychiatry, Istanbul, Turkey

Acut myocardial infarction (AMI) is a sudden, extremely stressful, potentially life-threatening event.

Aim: Participants will be able to describe the frequency and correlates of Acute stress disorder (ASD) and Posttraumatic stress disorder (PTSD) in patients with AMI.

Method: Seventy-six patients were evaluated during the first week and sixth month after AMI. A semistructured interview form, Clinician Administered PTSD Scale (CAPS), The Impact of Events Scale-Revised (IES-R), Hamilton Depression Rating Scale (HDRS), Hamilton Anxiety Rating Scale (HARS), Brief Illness Perception Questionnaire (BIPQ) were applied.

Results: We found the frequency of ASD and PTSD in AMI patients as 9.2% and 11.9%, respectively. Being alone during the AMI attack, transportation diffuculties, feeling threatened death, helplessness and horror were risk factors for PTSD. CAPS, IES, HDRS and HARS points were significantly higher in PTSD. Intrusion had the highest score. The disease perception factors as disorder significance, description, anxiety and emotion were positively correlated with PTSD.

Conclusion: Diagnosis and treatment of the patients with PTSD after AMI is required for preventing death risk related to disease, providing better occupational, social and familial lives and also treatment cooperation.

Exploratory Factor Analysis of the Bosnian Version of the Inventory of Complicated Grief (Abstract #196382)

Poster # S-109 (Civil Ref, Assess Dx) **Exhibition Hall, 4th Floor**

Craig, Carlton, PhD[1]; Sossou, Marie-Antoinette, PhD[1]

[1]University of Kentucky, Lexington, Kentucky, USA

The Inventory of Complicated Grief (ICG; Prigerson et al., 1995) is a 19-item, single factor measure of complicated grief that has a five-point response format that ranges from 0 never to 4 always for each item. It has demonstrated excellent internal consistency († = .94) and test-retest reliability (r = .80). However, in order to study populations from other cultures, translation of the English version into another language is often necessary. This study was part of a larger study that used a translation-back-translation method to convert the ICG into the Bosnian language. A survey package constituting 4 translated measures with the ICG being one of them was randomly distributed to 500 resettled Bosnians living in the Southern United States with 126 (25%) usable surveys being returned. An exploratory factor analysis of this translated Bosnian version of the ICG using principal axis extraction and promax rotation indicates a single factor structure with all 19 items having factor coefficients that range from .46 to .88 on one factor and accounting for 52.73% of the variance. Internal consistency is excellent († = .95). This Bosnian translation of the ICG has initial evidence of being a valid measure of complicated grief for Bosnian refugees.

The Impact of Therapeutic Engagement With Survivors of Trauma on a Sample of Irish Therapists

(Abstract #196384)

Poster # S-110 (Practice, Assess Dx) **Exhibition Hall, 4th Floor**

Daly, Margaret, BA(HONS), HDIPED, DIP PSYCH, MPSYCHSC (PSYCHOTHERAPY)[1]; Burke, Teresa, BSC, PhD[1]

[1]UCD School of Psychology, University College Dublin, Dublin, Ireland

Objectives: This study sought to examine the impact of therapeutic engagement with trauma survivors on a sample of Irish therapists and to study the prevalence of and relationships between vicarious traumatization (VT), compassion fatigue (CF) and burnout (BO).

Method: 164 trauma therapists completed a Therapist Information Questionnaire which examined therapist, client, workload and work-setting variables that might act as risk or protective factors for VT, CF or BO; the Professional Quality of Life Scale; Maslach Burnout Inventory and the Trauma and Attachment Belief Scale.

Results: While mean scores on VT, CF and BO were significantly lower than standardised norms, scores on Compassion Satisfaction and Personal Accomplishment were significantly higher. No notable differences in VT scores emerged between therapists with a personal history of trauma (n=83) and those without, but these therapists scored significantly higher on CF and EE than therapists with no trauma history. Satisfaction with professional and psychological self-care accounted for a significant proportion of variance.

Conclusions: This is an experienced, resilient sample of therapists and those with a history of trauma do not appear to be more vulnerable to VT than their counterparts. They do, however, appear to be more vulnerable to CF and EE.

Poster # S-111 (withdrawn)

Poster # S-112 (withdrawn)

Coping, Posttraumatic Stress Disorder and Comorbid Symptoms Among Active Military Personnel

(Abstract #196390)

Poster # S-113 (Practice, Mil Emer) **Exhibition Hall, 4th Floor**

Lavoie, Vicky, MPS.[1]; Guay, Stephane, PhD[2]; Boisvert, Jean-Marie, PhD[1]

[1]School of Psychology, Laval University and Centre Hospitalier Universitaire de Quebec, Canada

[2]Montreal University and Veterans Affairs Canada, Montreal, Quebec, Canada

Coping strategies have been shown to modulate the effects of trauma on posttraumatic stress symptoms, but less is known about how this variable could affect comorbid symptoms of PTSD. The purpose of this study was to examine how the various ways of coping with stress could predict comorbid symptoms of military personnel with PTSD. A sample of 33 Canadian militaries exposed to operational stress when deployed was recruited. Participants were assessed for PTSD diagnosis and were asked to complete self-report measures on PTSD symptoms, depression symptoms, worries and ways of coping with stress. Results: Hierarchical regression analyses indicate that ***avoidance strategies*** are positively linked with depression scores variance (β=.25; ***p*** <.05) and worries (β=.35; ***p*** <.05), while ***positive re-evaluation*** and ***problem solving*** are negatively linked (β=-.44; ***p*** <.01) with depression scores variance, even after controlling the severity of PTSD symptoms. Coping strategies seem to exert a unique and specific contribution on the prediction of different comorbid symptoms among military personnel with PTSD. Our findings suggest a need to adress comorbid symptoms of depression and worries with distinct strategies.

Poster # S-114 (withdrawn)

Poster # S-115 (withdrawn)

Relationship Between Personality Dimensions and Clinical Disorders in the Context of Lifetime Trauma

(Abstract #196396)

Poster # S-116 (Assess Dx, Clin Res) **Exhibition Hall, 4th Floor**

Basu, Archana, MA[1]; Von Eye, Alexander, PhD[1]; Levendosky, Alytia, PhD[1]; Bogat, G., PhD[1]
[1]Michigan State University, East Lansing, Michigan, USA

The current study compared 3 mechanisms of the relationship underlying personality dimensions and clinical disorders that have been proposed in the literature. Structural equation modeling was used to model the 3 mechanisms underlying personality functioning (negative and positive emotionality dimensions based on a five-factor model of personality) and clinical outcomes (depression and anxiety) in adulthood, in the context of childhood exposure to trauma and concurrent exposure to domestic violence in 195 adult women. First, the pathoplasty model suggests that clinical disorders and personality dimensions may be independent but have a synergistic relationship (RMSEA=.07 GFI=.86 CFI=.95). Second, the vulnerability model suggests that maladaptive personality traits increase predisposition for a clinical disorder (RMSEA=.06 GFI=.90 CFI=.96). Finally, the spectrum model suggests a dimensional model with common bases for personality and clinical disorders (RMSEA=.06 GFI=.92 CFI=.97). Chi-square difference tests indicate that the spectrum model provides the best fit. Personality dimensions were found to mediate the effects of childhood trauma and concurrent exposure to domestic violence. Thus, personality dimensions maybe viewed as extreme variants of clinical disorders and personality functioning could used as a broader context for understanding clinical disorders.

Reason for Non-Response to a Postdisaster Questionnaire Study

(Abstract #196397)

Poster # S-117 (Res Meth, Disaster) **Exhibition Hall, 4th Floor**

Hussain, Ajmal, MD[1]; Heir, Trond, PhD[1]
[1]Norwegian Centre for Violence and Traumatic Stress Studies, Oslo, Norway

A questionnaire was sent out in November 2006 linked to the Tsunami research program carried out by our research centre. Target population was all Norwegian citizens (adults) who were in a country hit by The Indian Ocean Tsunami 2004 at time of the disaster. As a consequence of relatively low response rate, 49%, we decided to determine the reasons for non-response.

A telephone survey (structured interviews) was performed on a systematic sample of non-responders from the target population. Ten statements were presented as reasons for non-attendance which the interviewed could agree or disagree with. Additionally, questions about exposure and posttraumatic stress were asked.

171 persons agreed to be interviewed. Persons interviewed did not differ significantly from the participating group regarding sex or age. The three most common reasons given for non- response were “My experiences were of lesser importance to the study” (60%), “The study was not of any use for me personally” (49%) and “The questionnaire was too long” (48%). Nine percent of the people found the study too personal and 35% agreed with the statement “The study reminded me too much of the disaster”.

The findings indicate that for the majority of non-responders to a postdisaster questionnaire study, non-response in not related to fear of retraumatization or high degree of posttraumatic stress.

After the Flood: A Study of Swedish Tsunami-Victims Between 16 and 19

(Abstract #196399)

Poster # S-118 (Child, Disaster) **Exhibition Hall, 4th Floor**

Uttervall, Mats, PhD-Student[1]; Eckerwald, Hedvig, Professor[2]; Lindam, Anna, MSc[3]; Hultman, Christina, Associate Professor[4]
[1]Department of Epidemiology and biostatistics, Karolinska Institutet, Stockholm, Sweden
[2]Department of Sociology, University of Uppsala, Uppsala, Sweden
[3]National Center for Disaster Psychiatry, University of Uppsala, Uppsala, Sweden
[4]Department of Medical Epidemiology and Biostatistics, Karolinska Institutet, Stockholm, Sweden

Studies of adolescents exposed to terror and trauma suggest different copying strategies. 14 months after the south-Asian tsunami in 2004, a questionnaire was sent out to 10 116 Swedish citizens who were in the area of the disaster. 4932 responded, of those were 293 in the age of 16 to 19. Five months after the questionnaire was sent out, a randomly chosen number in that age-group were approached to take part in a combined qualitative and quantitative study. They were interviewed about their reactions during the tsunami, life afterwards, their view on media and public authorities, current health-situation and their families. In addition to this it was possible to evaluate them on a quantitative basis and compare their reactions and stress-levels with others who had suffered the same trauma exposure. Altogether, this information creates a picture of how young people are affected by a traumatic event and their coping-strategies afterwards.

Sex-Related Difference in Stress-Induced BDNF Expression in Rat Cerebellum

(Abstract #196400)

Poster # S-119 (Bio Med, Res Meth) **Exhibition Hall, 4th Floor**

Zhang, Lei, MD[1]; Carlton, Janis, MD[1]; Xing, Guoqiang, PhD[2]; Li, He, MD[3]; Li, Xiaoxia, BS[3]; Ursano, Robert, MD[3]
[1]USUHS, Bethesda, Maryland, USA
[2]Department of Psychiatry, Uniformed Services University of the Health Science, Bethesda, Maryland, USA
[3]Psychiatry, USUHS, Bethesda, Maryland, USA

Background: Brain-derived neurotrophic factor (BDNF) is involved in neuroplasticity and is important for growth, survival, and activity-dependent synaptic strengthening in CNS. BDNF plays an important role in a variety of physiological and stressed conditions. Chronic stress-induced down regulation of BDNF can result in neuronal cell death in CNS and increases in BDNF have been associated with new learning. The cerebellum has been associated with several pathways and responses involved in acute and posttraumatic stress including regulation of altered sense of time, spatial memory, and fear memory consolidation.

Methods: We used quantitative real-time polymer chain reaction (qPCR) to measure mRNA for BDNF and its receptors TrkB, neural growth factor (NGF) and its receptor TrkA, and neurotrophin facts NT3 and NT4 and their receptor TrkC in cerebellum in stressed rats.

Results: We found a significant increase in expression of BDNF mRNA in male rats, while there was lower level of BDNF mRNA in female rats compared to control values. There were similar trends, but not statistically significant changes, for NGF, NT3, NT4, and their receptors.

Conclusions: If these sex-related differences in BDNF mRNA expression lead to reduced BDNF activity, they could contribute to the sex difference in adaptive activity after stress. This should be further determined.

Mentorship of Veterans Returning From Iraq and Afghanistan Using World War II Veterans

(Abstract #196401)

Poster # S-120 (Mil Emer, Practice) **Exhibition Hall, 4th Floor**

Bloeser, Katharine, MSW[1]; Reinhard, Matthew, PsyD[2]; Pollack, Stacey, PhD[3]

[1]Veterans Affairs Medical Center, Washington, District of Columbia, USA
[2]War Related Illness and Injury Study Center, Department of Veterans Affairs Medical Center, Washington, District of Columbia, USA
[3]PTSD Program, Washington VAMC, Washington, District of Columbia, USA

This presentation describes a pilot psychotherapy/psychoeducation group developed by the Washington, DC Veterans Affairs Medical Center Trauma Services team combining World War II Veterans with PTSD and OIF/OEF Veterans with PTSD. Two group sessions were held which focused on the similarities between the two veteran cohorts and their experiences. Group facilitators focused on the challenges of homecoming that both groups shared. These included psychosocial factors such as difficulties with employment and relationships as well as difficulties with substance abuse and depression. In keeping with program development, a brief survey was provided to both groups of veterans to ascertain their reactions to the session. Results of the survey concluded that both groups were surprised at the similarities in their experiences. OIF/OEF veterans were able to connect with the older generation easily and benefited from seeing the high levels of resiliency in the other group. World War II veterans who participated reported positive feelings surrounding their ability to help new soldiers returning home from combat. Group facilitators reported that most comments from both groups were appropriate and therapeutically valuable.

Death Notification in Japan

(Abstract #196402)

Poster # S-121 (Cul Div,Prev EI) **Exhibition Hall, 4th Floor**

Yanagita, Tami, PhD[1]

[1]Niigata University, Niigata, Japan

Sudden deaths resulting from accident, heart attack, suicide, violence take place everyday in the emergency rooms. Notification of sudden death leads left family to acute stress reaction and grief reaction. Among the tasks related to sudden death, death notification is one of the most difficult tasks for the medical staffs. In previous study we conducted questionnaire survey at emergency rooms in Japan to explore how death notifications are delivered in emergency settings. The result had showed high needs for having a working protocol to conduct appropriate death notification for left family, so that we conducted questionnaire survey at universities in Japan to explore their priority concerning death notifications. The questionnaire includes the items concerning “notification setting” and “timing of contact”. Although this survey is conducted as a preliminary examination, the purpose of the survey is to define the issues concerning death notification and optimize a working protocol for notifying and supporting left family. This survey is on going, the latest result will be presented.

In for the Long Haul: The Role of PTSD in Litigation Persistence in a Sexual Harassment Class

(Abstract #196403)

Poster # S-122 (Ethics, Assess Dx) **Exhibition Hall, 4th Floor**

Wright, Caroline Vaile, PhD[1]; Fitzgerald, Louise F., PhD[2]

[1]Summa-Kent State Center for the Treatment and Study of Traumatic Stress, Akron, Ohio, USA
[2]University of Illinois, Urbana-Champaign, Champaign, Illinois, USA

Women describe a variety of constraints that prevent them from reporting workplace sexual harassment experiences to employers, such as believing that nothing will be done and reluctance to cause problems for the harasser. The most common reason women cite, however, is fear; fear of retaliation, jeopardizing their career, experiencing shame and humiliation, and losing their privacy. The extent literature suggests these fears may be well founded; therefore it is thus not surprising that only between 5-30% of victims file formal complaints and less than 1% subsequently participate in litigation, where the majority of cases result in settlement or Alternative Dispute Resolution. The current study investigated which factors influence victims to persist with litigation in a sample of 492 class action litigants. Multinomial logistic regressions suggested litigants who accepted a first settlement offer as opposed to going to arbitration/mediation reported experiencing fewer PTSD symptoms in response to their harassment, felt less financially dependent on their job, and reported completing less formal education. Dominance analysis identified PTSD symptomology as the most dominant predictor in the model. Theoretical and practical implications for the role of PTSD and litigating sexual harassment claims are discussed.

Conceptual and Methodological Issues in Longitudinal Trauma-Related Research

(Abstract #196405)

Poster # S-123 (Res Meth, Assess Dx) **Exhibition Hall, 4th Floor**

Meyer, David, PhD[1]; Gulliver, Suzy, PhD[2]; Kamholz, Barbara, PhD[1]; Morissette, Sandra, PhD[1]; Knight, Jeffery, PhD[1]; Zimering, Rose, PhD[1]

[1]Psychology, VA Boston Healthcare System/Boston University, Boston, Massachusetts, USA
[2]VISN 17 Center of Excellence for Research on Returning War Veterans, and Texas A&M College of Medicine, Waco, Texas, USA

The existing literature on methodological issues encountered while conducting prospective, longitudinal research with trauma populations is limited in general and almost non-existent for emergency response personnel. This poster presentation is based on findings from an on-going study of the developmental patterns for PTSD and substance abuse in firefighter recruits, who by virtue of their profession are at risk for repeated exposure to traumatic events during their daily work. The sample includes a large cohort of firefighter recruits from 5 major metropolitan cities. Recruits complete a comprehensive baseline assessment during fire training academy. Those with non-clinical levels of symptoms are enrolled and evaluated every four months during their first three years in professional fire service. We will review and discuss critical methodological issues and challenges faced by researchers who repeatedly evaluate traumatic event exposure (A1, A2), conduct PTSD diagnostic interviews in the context of multiple traumatic events over time and struggle with retention of the sample over time. Discussion will focus on practical and conceptual issues that shape assessment protocols, long term retention of study participants, data collection procedures, and potentially introduce biases that can skew interpretations of observed symptom patterns.

Peritraumatic Predictors of Acute PTSD Symptoms in Mothers of Children Exposed to a Traumatic Event

(Abstract #196406)

Poster # S-124 (Assess Dx, Practice) **Exhibition Hall, 4th Floor**

Allenou, Charlotte, MA[1]; Brunet, Alain, PhD[2]; Bourdet-Loubére, Sylvie, PhD[1]; Olliac, Bertrand, MD[1]; Birmes, Philippe, PhD, MD[1]
[1]Laboratoire du Stress Traumatique, Toulouse, France
[2]Dept. Psychiatry, McGill University, Centre de Recherche Hìpital Douglas, Montréal, Quebec, Canada

Purpose: To assess the predictive power of peritraumatic dissociation and peritraumatic distress on the development of acute PTSD symptoms in a group of mothers whose child was involved in a serious motor vehicle accident.

Methods: Peritraumatic dissociation and distress were assessed by self-report among a group of 57 mothers in the week following the accident to their child while PTSD symptoms were assessed 4 weeks later by self-report as well as with a semi-structured interview. Results were analyzed using two-sided t-tests and in a linear regression. The alpha level was set at .05.

Findings: Compared to mothers with little or no acute PTSD symptoms, mothers with clinically significant PTSD symptoms had higher scores of peritraumatic dissociation (M=26 ; SD=13.9 vs. M=17.54 ; SD=7.5 ; t(54)=2.03, p<.05) and of peritraumatic distress (M=29.75 ; SD=9.2 vs. M=14.08 ; SD=9.3 ; t(54)=3.3, p<.05). Peritraumatic distress was the main predictor of acute PTSD symptoms (adjusted R2=0.21 ; standardized β=.47, p<.001).

Conclusion: These results confirm and extend the role of peritraumatic variables in the development of PTSD symptoms among a sample never studied before, that of mothers whose child experienced a psychological trauma.

Marine Resilience Study: Challenges of VA-DoD Collaboration for Prospective Longitudinal Research

(Abstract #196407)

Poster # S-125 (Mil Emer, Res Meth) **Exhibition Hall, 4th Floor**

Baker, Dewleen, MD[1]; Litz, Brett, PhD[2]; Nash, William, MD[3]
[1]University of California, San Diego, La Jolla, California, USA
[2]Psychiatry, VA Boston Healthcare System and Boston University, Boston, Massachusetts, USA
[3]Headquarters, Marine Corps, Quantico, Virginia, USA

The challenges of VA and military service collaboration in the planning and execution of prospective longitudinal research on risk and resilience for posttraumatic stress disorder in ground combatants will be discussed, and early results will be presented of the Marine Resilience Study, a large-scale military cohort study. Marine Resiliency Study: Challenges and Outcomes Combat is emotionally and physically challenging. Most war-related research so far has been retrospective, cross-sectional and insular, predominantly focusing on single systems. The objective of the Marine Resiliency Study is to complete a series of three prospective, longitudinal, interrelated psychosocial, biological and genetic projects that seek to better understand risk and resilience in Marines deploying to a combat zone. Subjects for this integrated study will be consenting male Marines from 2 infantry battalions; a pool of approximately 1600 eligible participants. The primary goals of this talk will be to 1) Briefly describe the study objectives and methods, 2) Discuss the challenges that must be met across the VA-military systems to set up and implement a collaborative study. These challenges include system specific rules, regulations and culture, as well as Institutional Review Board (IRB) issues, 3) To present preliminary outcomes for selected biological measures.

Psychosocial and Psychiatric Predictors of Trajectories of Adaptation to Combat Trauma
Exposure to at least one traumatic event in the war-zone is a necessary but not sufficient cause of chronic PTSD. Cross-sectional research has revealed a variety of additional psychosocial and psychiatric risk indicators that putatively create the sufficient conditions for the emergence of posttraumatic pathology, including demographics, prior exposure to highly stressful life events, history of mental health problems, retrospectively reported peritraumatic dissociation or panic, poor social and family supports, and other individual difference characteristics such as hardiness and self-esteem. The key challenge for the field, which the Marine Resilience Study aims to address, is to propose and test mechanisms of risk that mediate between stressor exposure and outcome over time. This presentation will discuss some of the challenges associated with assessing multiple psychosocial and psychiatric predictors and outcomes longitudinally in a military cohort, and present some of the early results of our study.

Peritraumatic Behavior Questionnaire (PBQ): A Proposed Third-Person Measure of Traumatic Stress
One of the significant challenges for military psychiatry is to identify those individuals in a combat zone who are at greatest risk for posttraumatic stress disorder so that they can be provided focused early interventions to reduce risk. Mere exposure to traumatic stressors is an insufficient indicator of risk, and studies have shown that peritraumatic psychological processes are stronger predictors of PTSD than are pre-trauma or post-trauma factors. A number of validated, self report measures of peritraumatic distress and dissociation exist, but relying on subjective self-report in a combat zone is problematic for several reasons, including those related to stigma and adaptive denial. To meet this need, the Peritraumatic Behavior Questionnaire (PBQ) was created as a third-person measure of observable peritraumatic behavioral change that can be used by medical personnel and chaplains in theater to identify service members possibly in need of early intervention. This presentation will review the development and early validation of the PBQ in pilot studies, and describe its role in the Marine Resilience Study.

Comparing the Factor Structure of the PCL in Nonclinical Hispanic and White Groups

(Abstract #196409)

Poster # S-126 (Assess Dx, Cul Div) **Exhibition Hall, 4th Floor**

Hoyt, Tim, MS[1]; Nason, Erica, BA[1]; Yeater, Elizabeth A., PhD[1]
[1]Department of Psychology, University of New Mexico, Albuquerque, New Mexico, USA

A number of models have been proposed with respect to the symptom structure of PTSD. The current study used confirmatory factor analysis (CFA) to compare the fit of ten symptom structure models of PTSD between Hispanic and White ethnic groups. PTSD symptoms were measured using the PTSD Checklist, Civilian version (PCL-C), which was completed by a diverse sample of nonclinical undergraduates (N = 504; 45% Hispanic; 66% Women) at a southwestern university. Of the models tested, only four models [3-factor (Anthony et al., 1999), 4-factor Dysphoria, 4-factor Avoidance, and 4-factor Numbing] had a CFI score above .9 in both populations. Overall, the PTSD models tested in this study were a better fit when applied to Hispanic populations with the 4-factor Avoidance model being the only exception (White CFI = .916, Hispanic CFI = .903). Additionally, Hispanic and White populations differed in which models were the best fit. The 4-Factor Numbing Model was the best fitting model among the Hispanic sample in this study (CFI = .938, X2 = 196.59, ECVI = 1.229, NFI = .867, RMSEA = .057) whereas the 4-Factor Avoidance model was the best fitting model among the White sample (CFI = .916, X2 = 269.61, ECVI = 1.262, NFI = .865, RMSEA=.071). This differential symptom structure suggests that interventions may need to be tailored to specific ethnic groups based on PTSD symptomatology.

The Assessment of Dissociation Symptoms in Patients With Mental Disorder by the DIS-Q Japanese

(Abstract #196410)

Poster # S-127 (Assess Dx, Cul Div) **Exhibition Hall, 4th Floor**

Matsui, Yusuke, MD, MDIV, ME, MESCI, MED, MENG, MFA, MGEOL[1]; Tanaka, Kiwamu, MD[2]; Fukushima, Haruko, MD[1]
[1]JSTSS, Kobe, Japan
[2]JSTSS, Kobe, Hyogo, Japan

This study investigates that patients with Dissociative Disorder (DDNOS), Obsessive-Compulsive Disorder (OCD), Eating Disorder (ED) by using the Structural Clinical Interview for *DSM-V* have dissociation symptoms by the Dissociative Experience Scale DES Japanese version and the Dissociation Questionnaire DIS-Q Japanese version of 89 outpatients. A test-retest procedure was conducted with a normative sample of 68 adolescents. The results showed good reliability concerning both internal consistency and test-retest stability. In this study, we exclude the patients with Schizophrenia, because we published a paper in previous study of our group. (Trauma-related Dissociative symptoms of patients with Schizophrenia, 2001). The intercorrelation matrix (Pearson ƒÁ) for total DIS-Q score in patients of Dissociation Disorder shows high intercorrelation between DIS-Q and DES (ƒÁ=0.724, p<0.01); similarly, Obsessive-Compulsive Disorder (ƒÁ=0.682,p<0.05), Eating Disorder(ƒÁ=0.659,p<0.05). In this study, we translate DIS-Q Japanese version under the permission of the author, Vanderlinden, is found between the DES and the DIS-Q, so the DIS-Q Japanese version has proven to be a screening instrument in the assessment of dissociative symptom in patients with DID, OCD, ED.

Racial Identity and Trauma: Understanding the Symptoms Reported by African American Victims

(Abstract #196412)

Poster # S-128 (Cul Div, Practice) **Exhibition Hall, 4th Floor**

Richmond, Adeya, MA[1]; Crouch, Julie, PhD[1]; Casanova, Gisele, PhD[2]
[1]Northern Illinois University, DeKalb, Illinois, USA
[2]Purdue University Calumet, Hammond, Indiana, USA

There is growing recognition that race-based traumatic stress may influence psychosocial functioning among racial minorities in the U.S., yet race-related adjustment is seldom considered in efforts to understand the functioning of victims seeking trauma-focused treatment. The present study examined whether measures of racial identity among African Americans were associated with a measure of trauma-related symptoms after controlling for lifetime victimization experiences.Three-hundred three (219 Caucasian, 84 African American) undergraduates completed measures of lifetime victimization, trauma symptoms, and racial identity. Regression analyses were conducted to examine whether racial identity development was associated with trauma symptoms after controlling for demographic factors and self reported lifetime victimization. for African American, but not Caucasian, respondents measures of racial identity were significantly associated with trauma symptoms even after controlling for lifetime trauma and other demographic factors. Findings suggest that measures of trauma symptoms may tap race-related stress independent of the impact of the more traditionally assessed victimization events (e.g., witnessing violence, physical assault, etc). These findings suggest race-related stress should be considered when interpreting trauma symptom profiles for African American victims.

Poster # S-129 (withdrawn)

Humilation, Terror, and Degradation in Women Sexually Abused as Children

(Abstract #196416)

Poster # S-130 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Armsworth, Mary, EDD[1]; Sutherland, R. John, MA[2]
[1]University of Houston, Houston, Texas, USA
[2]University of Houston & NC-PTSD, Houston, Texas, USA

Humiliation as it relates to trauma has been overlooked in the literature until recently but remains an area in need of further exploration (Hartling, 2005). Miller (1988) postulated that "humiliation threatens one's survival by threatening one's vital connections". To explore this notion, a sample of 40 women with childhood incest (from a larger qualitative interview study by the first author), included specific descriptions of trauma experienced, as well as participants' perceptions of their connectedness as children and as adults. All experienced incest that included humiliating acts such as sadistic rape and anal rape. Physical abuse was experienced by 85% of the sample, with the same percent hit with fists or objects, tissue damage in 75% of subjects, and being choked, restrained, kicked, burned, or bones broken in 15- 38% of reports. All participants reported emotional abuse with the following behaviors: 88% experienced humiliation, 85% were verbally abused, 45% were threatened with death or harm, and 75% were shunned and silenced. Disconnection and relational difficulties as a child and as an adult were reported by all of the 40 subjects. Survival methods included reliance on self, isolation, withdrawal, numbing, dissociation, and prayer. Further links between trauma, humiliation and degradation will be discussed, with implicatons for treatment provided.

Impact of Personality Traits and Negative Affect on PTSD in a Prospective Study of Police Officers

(Abstract #196417)

Poster # S-131 (Mil Emer, Assess Dx) **Exhibition Hall, 4th Floor**

Apfel, Brigitte, MD[1]; McCaslin, Shannon, PhD[1]; Inslicht, Sabra, PhD[1]; Metzler, Thomas, MA[1]; Wang, Zhen, MD[2]; Marmar, Charles, MD[1]
[1]University of California San Francisco, San Francisco, California, USA
[2]VAMC San Francisco, San Francisco, California, USA

Purpose: Peritraumatic emotional distress and dissociation are known risk factors for the development of PTSD. This prospective study examined the influence of personality traits and negative emotion prior to trauma exposure on PTSD symptoms.

Methods: In 136 police recruits personality traits, negative emotion, and prior trauma were assessed during academy training. Critical incident (CI) exposure, peritraumatic distress and dissociation, and posttraumatic stress symptoms were assessed after 24 months of active duty.

Findings: PTSD symptoms were significantly associated with neuroticism, negative affect, critical incident life threat exposure, and peritraumatic dissociation and distress. Employing path analysis, negative affect was found both to have a direct effect on PTSD symptoms and to mediate the effect of prior trauma via increased peritraumatic distress. Extraversion had a significant positive effect on CI exposure and a borderline significant negative effect on PTSD symptoms, while neuroticism was not longer a significant predictor of PTSD symptoms. CI exposure had a significant direct effect on PTSD symptoms.

Conclusions: Police recruits with greater negative affect prior to CI exposure may develop greater distress at the time of a trauma, resulting in more PTSD symptoms. Some aspects of extraversion may confer risk while other aspects may be protective.

A Critical Evaluation of Emotional Numbing as a Distinguishing Feature of PTSD

(Abstract #196422)

Poster # S-132 (Assess Dx, Res Meth) **Exhibition Hall, 4th Floor**

Slagle, David, PhD[1]; Gray, Matt, PhD[2]
[1]University of Wyoming, Laramie, Wyoming, USA
[2]Psychology, University of Wyoming, Laramie, Wyoming, USA

Emotional numbing (EN) has been purported to be distinguishing feature of posttraumatic stress disorder (PTSD). The present study evaluated whether EN distinguished individuals endorsing diagnostic levels of PTSD from those reporting diagnostic levels of depressive symptoms and those reporting non-diagnostic levels of PTSD or depressive symptoms. Participants consisted of 65 undergraduates who completed a self-report measure of affective valence twice a day for six days and self-report measures evaluating emotional intensity, trauma exposure, PTSD, and depressive symptoms. Participants in the PTSD group evidenced less positive affect (PA) and greater negative affect (NA) than those in the depressive group (PA d = -.31; NA d = .39) or those in the non-diagnostic group (PA d = -.52; NA d = 1.28). The PTSD group demonstrated less positive emotional intensity than the depressive (d = -.41) or non-diagnostic groups (d = -.85) and greater negative emotional intensity than the non-diagnostic group (d = .89). The PTSD group, not surprisingly, reported greater EN on a trauma symptom measure than the depressive (d = 1.98) or non-diagnostic (d = 3.16) groups. Non-trauma measures of emotion failed to distinguish the PTSD and depressive groups, suggesting that the EN may not distinguish PTSD from depression.

How Do We Help OEF/OIF Veterans With Post-Deployment Problems Enter and Stay in Psychotherapy?

(Abstract #196427)

Poster # S-133 (Practice, Mil Emer) **Exhibition Hall, 4th Floor**

Murphy, Ronald, PhD[1]; Thompson, Karin, PhD[2]; Stanton, Theresa, BA[1]; Bennett, Bruce, MHS PA-C[3]; Stanton, Eric, BA[4]
[1]Psychology, Francis Marion University, Florence, South Carolina, USA
[2]Memphis VA Medical Center, Memphis, Tennessee, USA
[3]Northampton VA Medical Center, Leeds, Massachusetts, USA
[4]United States Navy, Conway, South Carolina, USA

Research shows that many Iraq and Afghanistan veterans with post-deployment problems, such as PTSD, are not seeking help. Clinicians also report that even if veterans enter treatment, many are not remaining long enough to get adequate help. Despite this great need to engage these returning warriors in treatment, treatment engagement issues in PTSD have rarely been addressed either by researchers or clinicians in the field. The goal of the panel is to address issues that are critical to recruiting veterans into treatment. The panel members have diverse backgrounds as clinicians and researchers in PTSD among veterans, and will each briefly discuss from an empirical or clinical perspective one of the following issues in treatment engagement: research on motivation enhancement issues in PTSD treatment, the literature on PTSD treatment engagement among OEF/OIF returnees, the role of treatment expectations, fears, and beliefs, and barriers to treatment engagement. Panel members will also briefly discuss how to address these issues effectively with individual veterans and at the administrative/systems level. Panel member presentations will be kept brief, as the goal of the panel is to create a relevant and productive discussion of these treatment engagement issues among panel and audience members.

Effects of Childhood Physical Violence on Trauma Symptoms and Percieved Social Support Satisfaction

(Abstract #196428)

Poster # S-134 (Clin Res, Child) **Exhibition Hall, 4th Floor**

Bryant, Cody, BA[1]; Skinner, Sabrina, BA[1]; Legerski, Joanna, MA[1]; Fiore, Christine, PhD[1]
[1]University of Montana, Missoula, Montana, USA

Women who are physically abused as children are more likely to be in a violent relationship as an adult (Coid et al., 2001). In addition, IPV has been assoiciated with mental and physical health difficulties (Coker, 2002). Research indicates social support reduces by almost one half the risks of adverse mental health outcomes among women (Coker, 2002). To more fully understand the relationship between IPV victims, use of social support, trauma symptoms and their history of child abuse, quantitative data from 393 participants who have experienced IPV will be assessed. The participants in this study were obtained from a community sample within Montana. The subjects participated in a semi-structured interview and self-report assessments of social support access, perceived satisfaction and the Trauma Symptoms Checklist. Findings indicate adult women with only a history of child physical abuse showed no signifigant differences in trauma symptoms when compared with women who had no childhood history of abuse. However, women who had multiple childhood abuses including childhood physical abuse were found to be significant in adult trauma symptoms. The qualitative differences in social support usage will be discussed. Findings may provide insight into better ways to provide for women in a violent relationship.

Predicting Post-Trauma Quality of Life: Meaning-Making Trumps Medical Reality

(Abstract #196429)

Poster # S-135 (Clin Res, Mil Emer) **Exhibition Hall, 4th Floor**

De St. Aubin, Ed, PhD[1]; Valvano, Abbey, BS[1]; Deroon-Cassini, Terri, MS[1]; Hastings, Jim, PhD[2]; Horn, Patricia, PhD[2]
[1]Psychology, Marquette University, Milwaukee, Wisconsin, USA
[2]Spinal Chord Unit, Zablocki VA Medical Center, Milwaukee, Wisconsin, USA

This study, based on a large sample of US veterans who had experienced a spinal chord injury, was designed to investigate the relevance of individual differences in meaning-making as these relate to post-trauma adjustment (Bonanno, 2004; Hobfoll et. al., 2007). We combined two medical measures to constitute a score of objective severity of injury. This score was not related to any of four indices of quality of life: psychological, financial, physical, and social well-being. Subjective severity of injury was quantified as the participant's perception of the loss of physical resources and daily functioning ability. By subtracting the subjective from the objective score (z converted), we created a GAP variable. A GAP close to 0 indicates the participant is a realist who accurately perceives the severity of the injury. An optimist (high GAP) perceives the severity to be less than the objective reality and a defeatist (low GAP) overestimates the severity of the injury. The GAP scores were positively related to three of the four indices of post trauma quality of life: psychological, financial, and physical well-being. We then examined participant's narrative responses regarding meaning making (identity, ideology, spirituality) to discern differences in the trauma rhetoric of realists, defeatists, and optimists.

Lifelong Versus Trauma-Related Nightmares in a Treatment Seeking Sample

(Abstract #196430)

Poster # S-136 (Clin Res, Assess Dx) **Exhibition Hall, 4th Floor**

Davis, Joanne, PhD[1]; Ensor, Kristi, BA[1]; Byrd, Patricia, MA[1]; Rhudy, Jamie, PhD[1]

[1]University of Tulsa, Tulsa, Oklahoma, USA

Nightmares and sleep disturbances are increasingly viewed as potential key factors in the development and maintenance of long-term problems post-trauma. Little is currently known about potential differences between lifelong [LLN] and trauma-related nightmares [TRN]. Data will be presented from 66 treatment seeking trauma-exposed individuals, 69% of whom reported that nightmares began following a traumatic event. Those with TRN were more likely to report nightmares that were exact replays of the traumatic event and less likely to report nightmares unrelated to the trauma. Individuals with TRN experienced more distress including higher depression, frequency and severity of PTSD symptoms, panic symptoms upon waking from a nightmare, and poorer sleep quality. No differences were found for fear of sleep, frequency or severity of nightmares, dissociative symptoms, and physical health symptoms. Approximately half of these individuals were treated with a brief cognitive behavioral treatment targeting nightmares. Six-month follow-up assessments are almost complete and we will report on any differences in treatment outcome between those with LLN and TRN. Based on findings, implications for treatment will be discussed and directions of future research outlined.

Psychopathology and Response Style: Affecting Participants Response to Trauma Related Research

(Abstract #196431)

Poster # S-137 (Ethics, Clin Res) **Exhibition Hall, 4th Floor**

Pennington, Hannah, MA[1]; Newman, Elana, PhD[1]; Carlson, Eve, PhD[2]

[1]University of Tulsa, Tulsa, Oklahoma, USA
[2]National Center for PTSD, Menlo Park, California, USA

There is concern that trauma-related studies may evoke distress not already present in survivors. Participants with psychopathology have reported greater emotional upset but not more regret in regards to trauma-related research participation. In this study we explored the relationship between psychopathology & reactions to trauma-related research by evaluating RRPQ-R factor scores in a trauma exposed population. We then analyzed factors hypothesized to affect emotional reactivity: emotional labiliy, feeling unsupported when confiding in others, and emotion focused coping. Results show higher scores on major depression, PTSD, anxiety, and dysthymia scales were related to emotional reactivity, but not to appraisals of drawbacks or the value of participation. RRPQ-R Emotional Reactivity (ER) and the Affective Lability Scale were significantly related. RRPQ-R ER and Emotional Approach Coping scores were not related. A significant relationship emerged between RRPQ-R ER and the Social Constraints Scale. These results replicate previous findings, yet suggest that factors such as affective lability and perceived constraint from others are also related to emotional reactions during participation. Thus, emotionality may indicate ongoing distress and should not be assumed the product of the research experience without further investigation.

Imagery Vividness, Reexperiencing Symptoms, and Treatment Outcome

(Abstract #196432)

Poster # S-138 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Pennington, Hannah, MA[1]; Davis, Joanne, PhD[1]; Rhudy, Jamie, PhD[1]; Ensor, Kristi, BA[1]; Byrd, Patricia, MA[1]

[1]University of Tulsa, Tulsa, Oklahoma, USA

Research elucidating the relationship between vividness of imagery and posttraumatic stress symptomology is sparse. Imagery vividness has been related to greater PTSD symptomology and nightmare frequency. Bryant and Harvey (1996) found vividness of imagery related to nightmares and flashbacks. With increased anxiety, vivid imagery ability decreased and they suggest therapies utilizing imagery could be less effective with people who are lower in imagery ability or avoid imaginal exercises.

To further explore the relationship between imagery vividness and re-experiencing symptoms, it was hypothesized that better vivid imagery ability would be associated with reexperiencing symptoms in a sample of treatment seeking trauma survivors. Vividness of non-trauma imagery was associated with intrusive thoughts, flashbacks and emotional experiencing as predicted, yet not related to dreams. We further hypothesized that greater vividness of imagery would be related to a reduction in trauma related nightmares after treatment that included an imaginal exposure component. Results indicated that greater vividness of imagery at baseline was associated with the frequency of trauma-related nightmares in the past month post-treatment. This study provides evidence that vividness of imagery is not only related to reexperiencing symptoms, but may also be related to treatment response.

Treatment of Combat Related PTSD With Virtual Reality Exposure

(Abstract #196433)

Poster # S-139 (Clin Res, Mil Emer) **Exhibition Hall, 4th Floor**

Reger, Greg, PhD[1]; Rizzo, Albert, PhD[2]; Wilson, Jaime, PhD[3]; Mishkind, Matt, PhD[3]; Reger, Mark, PhD[1]; Gahm, Gregory, PhD[1]

[1]Telepsychological Health and Technology, National Center of Excellence, Tacoma, Washington, USA
[2]University of Southern California, Marina del Rey, California, USA
[3]Madigan Army Medical Center, Tacoma, Washington, USA

Virtual reality exposure has been used for the treatment of a variety of anxiety disorders including specific phobias and social anxiety disorder. Researchers and clinicians have more recently explored its utility for exposure therapy for combat-related posttraumatic stress disorder (PTSD). Service members returning from Iraq are at increased risk of posttraumatic stress disorder and one efficacious available treatment is prolonged exposure. A core component of this treatment is imaginal exposure, which involves confrontation of the index trauma in one's mind. VR may enhance emotional engagement and increase activation of the fear structure during exposure through multisensory stimuli that resemble aspects of the patient's traumatic memory. This presentation will review the findings of research exploring Soliders' attitudes about using VR in mental health treatment and the results of research assessing previously deployed Soldiers' subjective evaluation of the realism of a VR Iraq. Initial results from clinical applications with service members with combat-related PTSD will also be discussed. In the case that future research establishes the efficacy of VR exposure for PTSD, this technology may increase Service Members' willingness to seek and participate in treatment due to an approach that may be more appealing than traditional talk therapy.

Poster # S-140 (withdrawn)

Treating Nightmares in Trauma-Exposed Persons: Psychological and Physiological Outcomes

(Abstract #196435)

Poster # S-141 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Davis, Joanne, PhD[1]; Rhudy, Jamie, PhD[1]; Ensor, Kristi, BA[1]; Byrd, Patricia, MA[1]; Williams, Amy, MA[1]; McCabe, Klanci, MA[1]
[1]University of Tulsa, Tulsa, Oklahoma, USA

Sleep disturbance, including fear of going to sleep, difficulty maintaining sleep, and experiencing nightmares, is considered to be a hallmark of posttraumatic stress disorder (Ross et al., 1989). Research studies find that nightmares and other sleep disturbances are quite prevalent immediately following a trauma (Kilpatrick et al., 1998), are associated with severity of distress (Schreuder, Kleijn, & Rooijmans, 1999), are predictive of long-term functioning (Harvey & Bryant, 1998), and are resistant to both pharmacological and psychological interventions (e.g., Clark et al., 1999; forbes, Creamer, & Biddle, 2001). Variants of imagery rehearsal therapy are promising for the reduction of the severity and frequency of trauma-related and idiopathic nightmares, PTSD symptoms, depression, and improving sleep quality, based on several randomized clinical trials. No studies to date have examined the efficacy of targeted treatments on underlying physiological indices of distress. The present study reports on the outcome of randomized clinical trial of a three session treatment for chronic nightmares on psychological and physiological measures. The treatment component of the trial is complete and six month follow-up assessments are nearing completion. Based on findings, future clinical and research efforts will be discussed.

Alexithymia and Family Environment in Adult Survivors of Childhood Sexual Abuse

(Abstract #196436)

Poster # S-142 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Castillo, Yenys, MS[1]; Morrow, Jessie L., BA[2]; Hendel, Ruhama, BS[3]; Gold, Steven, N., PhD[4]
[1]Center for Psychological Studies, Nova Southeastern University, Hialeah Gardens, Florida, USA
[2]Center for Psychological Studies, Nova Southeastern University, Hollywood, Florida, USA
[3]Center for Psychological Studies, Nova Southeastern University, Plantation, Florida, USA
[4]Nova Southeastern University, Fort Lauderdale, Florida, USA

Purpose. Alexithymia involves difficulties defining physiological states or emotions with words. Limited research has suggested a relationship between alexithymia and a history of childhood sexual abuse or family dysfunction. We explored the relationship between self-reported alexithymia and dysfunction in clients' family of origin, in a sample of adult survivors of childhood sexual abuse (CSA). Methods. Participants were 87 adult survivors of CSA receiving psychotherapy in a private South Florida university clinic. The sample was 19.2% male, 80.8% female, with mean age 36 years (SD = 9.48) and ranging from 22-53 years. The Toronto Alexithymia Scale (TAS-20) was used. Consistent with the literature, a total TAS-20 score of 61 or higher was used to identify the presence of alexithymia. The Family Environment Scale (FES) was utilized to measure family dysfunction. Findings. Preliminary findings suggest that two FES scales (Intellectual-Cultural Orientation and Organization) are related to alexithymia. Conclusions. Preliminary findings suggest that alexithymia in CSA survivors is related to family interest in political, intellectual, and cultural activities, and the amount of family structure.

Assessing Axis-II Disorders With the Self-Report SNAP in a PTSD Sample

(Abstract #196437)

Poster # S-143 (Assess Dx, Practice) **Exhibition Hall, 4th Floor**

Wolf, Erika, MA[1]; Fabricant, Laura, BA[2]; Vanderhoef, Kimberly, BA[2]; Paysnick, Amy, BA[2]; Reardon, Annemarie, PhD[2]; Miller, Mark, PhD[2]
[1]National Center for PTSD, Boston University; VA Boston Healthcare System, Jamaica Plain, Massachusetts, USA
[2]National Center for PTSD, VA Boston Healthcare System, Boston, Massachusetts, USA

Posttraumatic stress disorder (PTSD) is associated with high rates of comorbid personality disorders (PDs). Assessing PDs in individuals undergoing PTSD evaluation and/or treatment provides useful information for case conceptualization and treatment planning. However, the use of structured diagnostic interviews for such purposes may be impractical. This study compared the performance of the Schedule for Nonadaptive and Adaptive Personality (SNAP; Clark, 2003), a 411-item true/false self-report inventory of PDs, to the International Personality Disorder Exam (IPDE; Loranger, 1999), a structured diagnostic interview, in a sample of 40 veterans (90% male) with current PTSD. Rates of PDs in the sample ranged from 0% for Dependent PD to 12.5% for Borderline PD. Initial results indicated that dimensional scores on the two measures tended to covary: (mean for all PDs: r = .40, range: r = .19 for Dependent PD to r = .57 for Antisocial PD). However, diagnostic agreement (kappa) between the two measures was poor (mean for disorders occurring in at least 5% of the sample = .21). These results suggest that the SNAP may be a useful, resource-efficient measure for assessing PD severity in the PTSD population but that the scoring algorithms for the diagnostic classifications require additional examination and refinement.

Applying the Concept of Violent Behavior as Etiological Stressor to Social Justice Controversies

(Abstract #196440)

Poster # S-144 (Ethics, Media) **Exhibition Hall, 4th Floor**

MacNair, Rachel M., PhD[1]
[1]Director, Institute for Integrated Social Analysis, Kansas City, Missouri, USA

Evidence suggests that the act of killing or committing other horrific violence may be an etiological stressor for PTSD at clinical or sub-clinical levels. Secondary analysis of the most extensive data base available, the large stratified random sample of the National Vietnam Veterans Readjustment Study, shows that such behavior may lead to more severe symptoms than other etiological stressors in the combat situation. Small studies and case studies show this concept may be applicable in a wide range of issues beyond that of direct combat. Questions about specific issues include: How does the theory of the traumatic nature of inflicting violence on others apply to those who participate in torture? How does it apply to those who carry out judicially-approved executions? What impact might this have on policy? What impact might it have in the public debate and the persuasiveness of the case against these forms of violence, as people consider not merely the victims but the people who must carry out policy? Is there any evidence for the debate over whether or not abortion is simply medicine or actually violence? Would it have any policy implications for workers compensation for police who shoot in the line of duty? Are there any implications for blood sports or slaughterhouses? Does it say anything about the therapy needs for those who have committed criminal homicide?

Criterion A Exposure in the Aftermath of Traumatic Brain Injury

(Abstract #196442)

Poster # S-145 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Larsen, Debra, PhD[1]

[1]*Institute of Rural Health, Idaho State University, Pocatello, Idaho, USA*

Purpose: This project explores the lifetime history of Criterion A exposure for individuals with a history of traumatic brain injury (TBI).

Methods: Each participant completed a structured interview regarding TBI history and the Stressful Life Experience Screen (SLES; Stamm & Rudolph, 1996) for both pre- and post-head injury.

Findings: Participants' average age at the time of head injury was 19.4 (SD=11.1) and the number of years since the TBI averaged 17.9 (SD=11.8). The average number of Criterion A categories participants endorsed as happening prior to their TBI was 3.24 (SD=2.09), which is not significantly different from the general public (mean=2.82; SD=2.9). However, post-TBI Criterion A experiences were reported at 5.84 average (SD=2.53), significantly higher than both the general population (t=5.97, p=.000) and the pre-TBI reports for this sample (t=5.14, p=000).

Conclusions: Results suggest that TBI survivors are at risk for elevated rates of criterion A exposure. This may be due to impulsivity or impaired decision making associated with TBI deficits.

Poster # S-146 (withdrawn)

Poster # S-147 (withdrawn)

Poster # S-148 (withdrawn)

Gender Differences Among Outpatients With Posttraumatic Stress and Substance Use Disorders

(Abstract #196451)

Poster # S-149 (Assess Dx, Cul Div) **Exhibition Hall, 4th Floor**

Possemato, Kyle, PhD[1]**; Bishop, Todd, MA**[2]**; Silver, Rebecca, MA**[3]**; Tirone, Vanessa, BA**[4]**; Ouimette, Paige, PhD**[5]

[1]*Center for Integrated Research, Veterans Affairs Medical Center, Syracuse, New York, USA*
[2]*Psychology, Syracuse University, Syracuse, New York, USA*
[3]*Clinical Psychology, Syracuse VAMC, Syracuse, New York, USA*
[4]*Veterans Affairs Medical Center, Syracuse, New York, USA*
[5]*Center for Integrated Healthcare, Syracuse VAMC, Syracuse, New York, USA*

Community studies consistently find that women have higher rates of PTSD than men. In contrast, studies of SUD patients suggest an attenuation of gender differences in PTSD, suggesting potential gender-linked etiological differences (Stewart et al., 2006). This study further explores gender differences in PTSD in an ongoing study of SUD outpatients. To date, 44 participants have completed clinical research interviews assessing PTSD, and alcohol and drug use (target N =168). Approximately, half of the sample is female (48%), and Caucasian (56%), with an average age of 33 years. Results will explore whether specific trauma, PTSD, and substance abuse characteristics are linked to gender. A more comprehensive understanding of gender, PTSD, and SUD will help inform future assessment and intervention methods for this difficult to treat population.

Brief Intervention for Alcohol Misuse Among Returning Veterans

(Abstract #196454)

Poster # S-150 (Clin Res, Mil Emer) **Exhibition Hall, 4th Floor**

McDevitt-Murphy, Meghan, PhD[1]**; Murphy, James, PhD**[1]**; Monti, Peter, PhD**[2]**; Shea, M. Tracie, PhD**[2]**; Miller, Ivan, PhD**[2]**; Zlotnick, Caron, PhD**[2]

[1]*University of Memphis, Memphis, Tennessee, USA*
[2]*Brown University, Providence, Rhode Island, USA*

The proposed work would describe the development of a brief intervention aimed at reducing alcohol abuse among veterans returning from combat tours in Iraq and Afghanistan (OEF/OIF veterans). The intervention is based on the Screening Brief Intervention and Referral to Treatment (SBIRT) model and is tailored to the needs of this population. Participants are recruited from a primary care clinic dedicated to the needs of OEF/OIF veterans at a large Veterans Affairs Medical Center. All veterans attending the clinic are offered the opportunity to complete a screening packet. Participants obtaining a score of 8 or greater on the Alcohol Use Disorders Identification Test (AUDIT) are offered the opportunity to participate in the full study. Participants are randomized to receive personalized feedback and psychoeducation delivered either with or without a motivational interviewing (MI) session. Personalized feedback includes content about symptoms of PTSD that may contribute to hazardous drinking as well as positive and negative coping skills employed. Goals for the intervention include reduction in hazardous alcohol use and engagement in formal mental health treatment for those with clinically significant symptoms of PTSD. Recruitment was initiated in February 2008 and preliminary results will be available by November 2008. (Supported by NIAAA K23AA016120).

Differential Pathways to Drug Versus Alcohol Abuse in Veterans With PTSD

(Abstract #196457)

Poster # S-151 (Assess Dx, Practice) **Exhibition Hall, 4th Floor**

Reardon, Annemarie, PhD[1]**; Fabricant, Laura, BA**[2]**; Vanderhoef, Kimberly, BA**[3]**; Wolf, Erika, BA**[4]**; Klunk-Gillis, Julie, PhD**[2]**; Miller, Mark, PhD**[2]

[1]*National Center for PTSD, Boston, Massachusetts, USA*
[2]*National Center for PTSD, Behavioral Sciences Division, VA Boston Healthcare System, Boston, Massachusetts, USA*
[3]*National Center for PTSD, VA Boston Healthcare System, Boston, Massachusetts, USA*
[4]*Boston University, Jamaica Plain, Massachusetts, USA*

Substance abuse occurs in 50-85% of individuals with PTSD. Recent research has demonstrated the role of personality traits in mediating the relationship between PTSD and substance use. In the current study we sought to examine whether PTSD comorbidity, in addition to personality traits, explains the differential pathways to drug and alcohol abuse. Structured clinical interviews were administered to 77 veterans to assess PTSD severity and Axis I and II diagnostic status; personality traits were assessed with the Multidimensional Personality Questionnaire. In this sample, 72% of participants met diagnostic criteria for a substance use disorder. Alcohol abuse was significantly associated with PTSD avoidance and numbing severity ($r = .27$, $p < .05$), Negative Emotionality ($r = .23$, $p < .05$), and Constraint ($r = -.24$, $p < .05$). Drug use was associated with ADHD ($r = .23$, $p<.05$), and Borderline Personality Disorder ($r = .33$, $p < .01$). These results suggest the presence of differential associations between PTSD and drug use and PTSD and alcohol use.

The Emotional Cost of Resiliency Following a Residential Fire

(Abstract #196459)

Poster # S-152 (Child, Disaster) **Exhibition Hall, 4th Floor**

Schwartz, Kathryn, BA[1]; Jones, Russell, PhD[1]

[1]Virginia Polytechnic Institute and State University, Blacksburg, Virginia, USA

There has been debate in the resilience literature about whether resilience should include internal adaptation or whether external adaptation is enough to constitute resilience. Initially, resilience was conceptualized as behavioral competence following exposure to adversity. This led to the finding, however, that individuals who had been identified as resilient were found to be experiencing increased levels of anxiety and depression. The current study attempted to address the question of whether competence is associated with higher levels of internalizing symptoms following a residential fire. It was hypothesized that those who exhibit competence would, in fact, experience elevated levels of psychopathology as compared to their less competent peers. Competence ratings were obtained using the Child Behavior Checklist (CBCL; Achenbach) as well as measures of internalizing symptoms. The Child's Reactions to Traumatic Stress (CRTES; Jones) was used to assess Posttraumatic Stress symptoms. Preliminary analyses suggest that competence is not significantly correlated with PTSD; however a significant relationship does exist between competence and overall internalizing symptoms. Future analyses include examining the relationship between the different clusters of PTSD symptoms and competence, as well as their relationship to other internalizing symptoms.

The Relationship Between Age of Trauma Exposure, PTSD Severity and Personality Disorders

(Abstract #196460)

Poster # S-153 (Practice, Assess Dx) **Exhibition Hall, 4th Floor**

Vanderhoef, Kimberly, BA[1]; Reardon, Annemarie, PhD[1]; Fabricant, Laura, BA[1]; Klunk-Gillis, Julie, PhD[1]; Paysnick, Amy, BA[1]; Miller, Mark, PhD[1]

[1]National Center for PTSD, Behavioral Sciences Division, VA Boston Healthcare System, Boston, Massachusetts, USA

Previous research has demonstrated associations between trauma exposure, PTSD and personality disorders (PDs). In the current study, we examined associations between age of trauma (i.e., child vs. adult, or combined), number of traumatic events, PTSD severity, and PD symptoms. Seventy-five veterans with PTSD completed the Traumatic Life Events Questionnaire to determine number and type of traumatic events experienced. The event indicated as most distressing was assessed using the Clinician-Administered PTSD Scale for *DSM-IV* (CAPS) to determine PTSD symptom severity and PD severity was assessed through the International Personality Disorder Exam (IPDE). Analyses indicated that both PTSD severity and number of traumatic events predict dimensional PD severity scores ($r = .40$, $p<.01$, $r = .38$, $p<.01$, respectively). Additionally, age of trauma predicted differential pathways to PDs. for individuals with childhood traumas only, there was an association between number of events and Narcissistic Personality Disorder symptom severity ($r = .65$, $p< .05$). for individuals with adulthood traumas only, there was no association with PD symptom severity. Combined trauma type predicted Borderline Personality Disorder ($r =.39$, $p = .05$), Histrionic Personality Disorder ($r = .40$, $p = .05$), and Paranoid Personality Disorder ($r = .33$, $p = .05$) severity scores.

Bearing Witness to Torture and the Abuse of Human Rights

(Abstract #196466)

Poster # S-154 (Ethics, Practice) **Exhibition Hall, 4th Floor**

Okawa, Judy B., PhD[1]; Piwowarczyk, Linda, MD, MPH[2]; Fabri, Mary, PsyD[3]; Ignatius, Sarah, JD[4]; Grodin, Michael, MD[5]; Crosby, Sondra, MD[6]; Keane, Terence, PhD[7]

[1]Center for Traumatic Stress Studies, PLLC, Washington, District of Columbia, USA
[2]Boston Center for Refugee Health & Human Rights/Boston University School of Medicine, Boston, Massachusetts, USA
[3]Marjorie Kovler Center for Treatment of Torture Victims, Chicago, Illinois, USA
[4]PAIR Project, Boston, Massachusetts, USA
[5]Psychiatry, Boston Center for Refugee Health and Human Rights, Boston, Massachusetts, USA
[6]General Internal Medicine, Boston Center for Refugee Health and Human Rights, Boston, Massachusetts, USA
[7]Psychiatry, Boston University School of Medicine, Boston, Massachusetts, USA

This presentation discusses: (1) survey results on the evolutionary process clinicians go through in order to bear witness to torture accounts; (2) challenges in asylum work and survey results on secondary trauma in asylum attorneys; and (3) the benefits of adopting a human rights perspective of engaging in participatory action in torture treatment work.

Bearing Witness to Torture: The Evolution of the Clinician

Bearing witness to stories of overwhelming cruelty recounted by survivors of politically motivated torture leads the clinician on a convoluted path through secondary trauma and posttraumatic growth. This presentation will describe the results of a preliminary survey of senior torture treatment specialists who were asked to describe the process of evolution they have experienced in order to be able to cope with its traumatic impact and to continue to work effectively with survivors.

In addition to symptoms of secondary trauma, many clinicians described initial experiences that echo survivors' experiences in a way, such as feeling devastated by the clear evidence of evil in the world, experiencing a sense of isolation, feeling silenced, and experiencing a change in the belief that people are basically trustworthy. Clinicians described developing an increasing ability to "hold" accounts of torture that deepened with increased familiarity with these experiences and with emerging confidence that bearing witness to these stories in itself helped ease survivors' pain. Many clinicians revealed that becoming socially active in speaking out against human rights abuses defrayed their sense of helplessness in the face of man's inhumanity to man and gave voice to those survivors whose voices have been temporarily silenced.

Secondary Trauma in Asylum Attorneys

According to the UN Declaration of Human Rights, individuals have the right to seek and enjoy asylum from persecution in other countries. Within one year of arriving in the United States, individuals must apply for asylum. This involves presenting their cases to an immigration officer. Some cases, however, are referred to an immigration judge for adjudication. There is a role for both health and mental health professional in providing evaluations for those who seek asylum. Various challenges related to this process will be described. It has been demonstrated that being represented by an immigration lawyer increases the success rate of asylum claims. Asylum lawyers are exposed to hearing the traumatic accounts of their clients who have experienced serious human rights violations, have been forced to flee their countries due to persecution, and sometimes have been exposed to atrocities. Results of a mail-out study looking at secondary trauma in asylum lawyers will be described as well as the implications for their training.

Wearing the Lenses of Human Rights
Therapists who work with severe trauma are often affected by the secondary traumatization inherent in bearing witness to the testimonies of clients. Focus on self-care is essential for long-term work with traumatized individuals. Another aspect of maintaining a healthy clinical perspective in trauma work, however, involves the conceptualization of meaning of interventions. A human rights perspective allows the therapist to have a context that has the potential to create alternate psychological practices. This presentation will discuss the work within the torture rehabilitation field where clinicians frequently engage in participatory action that creates a relationship of solidarity with the torture survivor. Conventional therapeutic frame issues will be discussed in the context of power dynamics, culture, and justice. Examples of therapeutic work with torture survivors will illustrate how participatory action can result in stronger therapeutic relationships between the survivor and clinician.

Participant Alert: This presentation may contain examples of torture experiences that could be disturbing to some participants.

Ego Development as an Indicator of Resiliency in Adults Sexually Abused as Children

(Abstract #196468)

Poster # S-155 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Armsworth, Mary, EDD[1]; Sutherland, R. John, MA[2]; Ortiz-Rodriguez, Tierra, BA[1]; Sackllah, George, BA[1]
[1]University of Houston, Houston, Texas, USA
[2]University of Houston & NC-PTSD, Houston, Texas, USA

Individuals who have experienced sexual abuse in childhood (CSA) are at risk for developmental alterations of personality, influencing the formation of his or her frame of reference and one's interpersonal world. To further understand levels of functioning and resilience in a sample of 62 adults with histories of CSA, (n= 31 males, n= 31 females), participants completed Loevinger's Washington Sentence Completion Test, strongly influenced by Piaget's work, that examines stages of ego development. The SCT yields three hierarchical levels with eight qualitatively different stages and reflects an individual's impulse control, character development, cognitive complexity, and conscious preoccupations. Two trained raters for the SCT rated items for males and females to determine ego levels, with inter-rater reliability established by two other independent raters. Analyses compared the distribution of male and female ego levels obtained from the SCT. In addition, a series of ad hoc analyses were conducted to examine salient responses from demographic descriptive data for further understanding of results obtained. Results indicated that sexual abuse in childhood may not necessarily delay or arrest ego development and may indicate the individual's reliance on resilient coping, education, and other means for surviving. Clinical applications will be discussed.

Aggressive Driving in Male VA PTSD Patients

(Abstract #196470)

Poster # S-156 (Mil Emer, Practice) **Exhibition Hall, 4th Floor**

Kuhn, Eric, PhD[1]; Drescher, Kent, PhD[2]; Ruzek, Josef, PhD[3]
[1]Sierra Pacific MIRECC, VA Palo Alto Health Care System, Menlo Park, California, USA
[2]NCPTSD-VAMC Palo Alto, San Jose, California, USA
[3]VA National Center for PTSD, Menlo Park, California, USA

Offensive combat driving is clearly adaptive in war zones. Stateside, however, this type of driving presents obvious dangers. Aggressive driving (AD) has been studied in the general population but has not been researched in combat veterans with PTSD. Therefore, this study examines AD in Afghanistan and Iraq war veterans and other war veteran cohorts. The relationship between AD and PTSD symptom severity and war-zone blast exposure is also examined. Participants were 529 VA PTSD men's residential rehabilitation program patients. Among recent returnees, 60% reported having made verbal outbursts or angry hand gestures and approximately 20% reported having tailgated, intentionally cut-off, or chased other drivers in the past 4 months. These rates are nearly double those reported by Gulf or Vietnam War veterans. PTSD severity related to AD, including frequency of AD. Rates were higher for recent returnees with war-zone blast exposure. These finding show that AD is common in veterans being treated for PTSD and may be more of an issue for recent returnees than other veterans. The unique experiences of the newest veterans, including blast exposure and encountering trauma triggers while driving are discussed. Findings are also discussed in terms of their implications for future research and clinical efforts.

Long-Term Effects of a Flood

(Abstract #196472)

Poster # S-157 (Disaster, Res Meth) **Exhibition Hall, 4th Floor**

Maltais, Danielle, PhD[1]; Lachance, Lise, PhD[1]; Gauthier, Simon, BASC[1]
[1]Human Science, Universite du Quebec Chicoutimi, Chicoutimi, Quebec, Canada

In July 1996, floods disrupted the lives of people living in rural and urban communities in the Saguenay area. Data collected three years after the events showed that victims demonstrated more posttraumatic symptoms, somatic symptoms, social dysfunctions, and depressive symptoms than non-victims. Victims also showed significantly lower levels of psychological well-being than non-victims. In order to identify the long-term impacts of flood exposure, a second study was conducted eight years after the event with the same groups of victims (N=129) and non-victims (N=89). Analyses show that urban survivors obtained improved scores on scales measuring PTSD, and depression yet remained significantly more affected than non-victims. Over time, victims also obtained improved scores on the GHQ-28 and the Affect Balance Scale yet also remained significantly different from non-victims on the GHQ-28. Rural victims improved their GHQ scores over time as well, yet maintained significant differences with rural non-victims for the PTSD score. No significant differences were observed over time (time 1 and time 2) or between groups (victims and non-victims) regarding psychological well-being and depressive symptoms in rural area.

Evaluation of Psychological Distress and PTSD in Colombians Displaced by Armed Conflict

(Abstract #196474)

Poster # S-158 (Civil Ref, Assess Dx) **Exhibition Hall, 4th Floor**

Richards, Anne, MD, MPH[1]; Ospina-Duque, Jorge, MD[2]; Marmar, Charles, MD[1]
[1]University of California San Francisco, San Francisco, California, USA
[2]Psychiatry, Universidad de Antioquia, Medellin, Region of Antioquia, Colombia

Purpose: To identify symptoms of psychological distress and treatment needs in Colombians internally displaced by armed conflict.

Methods: Focus groups and standardized surveys will identify the mental health problems, and psychosocial and treatment needs, of adult Colombians displaced by armed conflict and residing in Medellin. The sample is a convenience sample of individuals presenting to an NGO- and government-administered center providing support services for internally displaced people in Medellin. Focus groups will be homogeneous with respect to gender and ethnoracial status to identify differences in symptoms and needs amongst various population sub-groups. In addition to completing standardized surveys, participants will assess the relevance of the completed questionnaires to their experiences, in order to assess the value of the PTSD construct for this population.

Findings: NVIVO statistical software will be utilized to identify local idioms of distress and generate new hypotheses about the psychosocial consequences of armed conflict in Colombia. SPSS will be used to determine rates of PTSD, depression and anxiety symptoms and their relationship to demographic variables in this sample.

Conclusions: These findings will identify treatment needs and future directions for research in a highly traumatized and underserved population in Colombia.

Trauma-Related Guilt, Wrongdoing as a Mediator Between Posttraumatic Distress and Sexual Concerns

(Abstract #196477)

Poster # S-159 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Blain, Leah, BA[1]; Koucky, Ellen, BA[1]; Galovski, Tara, PhD[1]
[1]Center for Trauma Recovery, University of Missouri-St. Louis, St. Louis, Missouri, USA

Survivors of interpersonal trauma experience increased sexual concerns (SCs) as compared to non-survivors (Steel & Claes, 2007). To date, no study has addressed the role of posttraumatic guilt, which is a common reaction for many interpersonal trauma survivors (Resick, 2001). Current analyses were conducted on a sample of 11 initial participants from part of an NIMH-funded grant evaluating Cognitive Processing Therapy effectiveness. Participants completed the Posttraumatic Stress Diagnostic Scale, the Trauma-Related Guilt Inventory, and the Trauma Symptom Inventory. Regression analyses revealed that trauma-related guilt, specifically wrongdoing, significantly predicted SCs ($F= 28.82$, $p< .05$, adjusted $R2= -.74$), such that increasing guilt predicted decreasing SCs. Mediation analyses revealed that posttraumatic stress symptoms (PSSs) significantly predicted wrongdoing at a more liberal p-value ($F= 3.25$, $p< .10$, adjusted $R2= .14$), and that PSSs and wrongdoing significantly predicted SCs ($F= 13.86$, $p< .005$, adjusted $R2= .72$). A Sobel test of the mediation was significant ($z= 2.50$, $p< .05$). The finding that increasing guilt predicted decreasing SCs is surprising and warrants further investigation. We expect to have a sample 40 individuals by November 2008, and an even stronger relationship is anticipated with more data.

False Positives on the PTSD Checklist (PCL) Among Outpatients With Substance Abuse Disorders (SUD)

(Abstract #196478)

Poster # S-160 (Assess Dx, Res Meth) **Exhibition Hall, 4th Floor**

Andersen, Judith, PhD[1]; Silver, Rebecca, MA[2]; Bishop, Todd, MA[3]; Tirone, Vanessa, BS[1]; Ouimette, Paige, PhD[4]
[1]Veterans Affairs Medical Center, Syracuse, New York, USA
[2]Clinical Psychology, Syracuse University, Syracuse, New York, USA
[3]Psychology, Syracuse University, Syracuse, New York, USA
[4]Center for Integrated Healthcare, Syracuse VA Medical Center, Syracuse, New York, USA

Previous literature shows that the PCL performs well as a screening tool in outpatient samples. for our ongoing research with SUD outpatients, we use the PCL symptom scoring approach to identify participants with partial/full PTSD for enrollment. Given the high costs of false positives for the purposes of the research project, we sought to characterize reasons for false positive screens to improve screening methods. A total of 44 participants screened positive on the PCL yet 29% (N=13) did not have partial or full PTSD upon research interview, as confirmed by the CAPS (Clinician-Administered PTSD Scale). Males were more likely to be false positives (69%) than women. Patient endorsed reasons for false positives included that PCL self-reports reflected symptoms of depression, non-traumatic stress, and withdrawal, and faking for monetary compensation. Implications for screening among SUD outpatients will be described as well as potential explanations for identified gender differences.

Social Adjustment and PTSD Symptoms in NYC Police Officers Exposed to the WTC Terrorist Attack

(Abstract #196481)

Poster # S-161 (Disaster, Assess Dx) **Exhibition Hall, 4th Floor**

Jun, Janie, BA[1]; Metzler, Thomas, MA[1]; Henn-Haase, Clare, PsyD[1]; Best, Suzanne, PhD[1]; Marmar, Charles, MD[1]
[1]University of California San Francisco; Veterans Affairs Medical Center, San Francisco, California, USA

A measure of social situation and adjustment within different areas of functioning (e.g. work, social and leisure activities, and relationship with family) may be an indicator of how well one will adapt to a traumatic event; thus, predicting the risk to developing PTSD symptoms. Prior to 9/11 urban police officers from NYC, Oakland, and San Jose (n=747) were assessed to research their risk and resiliency to PTSD. After the World Trade Center terrorist attack occurred, follow-up assessments were administered. In this study we assessed NYC police officers (n=292) who have been exposed to the WTC terrorist attack. We examined the relationship between their work and interpersonal adjustment prior to 9/11 (Social Adjustment Scale Self-Report; SAS-SR) and PTSD symptoms post 9/11 (PTSD Checklist; PCL). We found a significant positive relationship between social maladjustment prior to 9/11 and PTSD symptoms post 9/11 (β=.26, t=5.04, $p<.00$), controlling for PTSD symptoms pre 9/11 and exposure to the WTC disaster relief operations. Additionally we found a positive relationship between social maladjustment pre 9/11 and general psychiatric symptoms (SCL 90-GSI) post 9/11 (β=.15, t=2.44, $p<.02$), controlling for psychiatric symptoms prior to 9/11 and exposure. These results indicate that social maladjustment may be a risk factor for PTSD and other psychiatric disorders.

Psychogenic Factors in the Typological Formation of Non-Psychotic Disturbances After Brain Damage

(Abstract #196482)

Poster # S-162 (Assess Dx, Practice) **Exhibition Hall, 4th Floor**

Margaryan, Samvel, PhD[1]
[1]Center "Stress", Yerevan, Armenia

Objective: to find how psychogenic factors conduce to the development of non-psychotic disturbances due to brain damage.

Methods: 124 patients (mainly war participants) after brain damage had been examined at the Center "Stress." Using specially designed questionnaires the psychiatric states of the mentioned patients had assessed. They also completed SCL-90 checklist.

Results: The psychopathological analysis showed, that the patients could be distributed into 3 groups. 31 of them had developed asthenic-depressive disturbances (Gr1), 57-personality changes (Gr2), 36-nosophobic and hypochondriacal disturbances (Gr3). 90% of patients of the Gr2 were affected by severe psychogenic factors such as reminiscences of war, painful losses, family poverty, but only 32% of patients in Gr1 and 22% of patients in Gr3 had the same influences. So the number of distressed patients in the personality changes group was significantly higher than in the other groups ($p<0.001$). The hostility is significantly higher in group B according to SCL-90, than in groups A ($p< 0.05$) and C ($p<0.001$).

Conclusions: The psychogenic factors are of great importance in the development of personality changes and social disadaptation, so it is important from the early stages after brain damage carry out psychotherapeutic treatment to prevent the pathological development of personality.

Smoking Motives Among Veterans Returning From Iraq or Afghanistan

(Abstract #196484)

Poster # S-163 (Mil Emer, Clin Res) **Exhibition Hall, 4th Floor**

Calhoun, Patrick S., PhD[1]; Green, Kimberly T., MS[2]; Davison, Rita M., BA[2]; Pender, Mary C., PhD[2]; Dedert, Eric A., PhD[3]; Beckham, Jean C., PhD[1]

[1]VA Mental Illness Research, Education, and Clinical Center and Duke University Medical Center, Durham, North Carolina, USA
[2]VA Mid-Atlantic Mental Illness Research, Education and Clinical Center (MIRECC), Durham, North Carolina, USA
[3]Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, North Carolina, USA

More deaths are caused by smoking related illness than suicide and homicide combined. While PTSD is associated with increased risk of smoking and decreased odds of smoking cessation, little is known regarding the mechanisms that underlie these vulnerabilities. Recent models of addiction propose that drug outcome expectancies influence drug utilization. The current study examined the relationship between PTSD and smoking outcome expectancies in veterans deployed to Afghanistan or Iraq. The sample (N=251) completed the Structured Clinical Interview for *DSM-IV*, the Combat Exposure Scale (CES), the Fagerstrîm Test of Nicotine Dependence, and the Smoking Consequences Questionnaire. Analyses compared smoking outcome expectancies between smokers with and without PTSD. Smoking was associated with CES (r=.14, p<.03) and was more prevalent among veterans with PTSD (41% vs. 23%; p<.003). Among current smokers (n=76), there were no differences between those with and without PTSD in nicotine dependence or in the number of cigarettes smoked. PTSD smokers, however, reported greater expectancies for negative affect reduction, boredom reduction, state enhancement, and social facilitation. Significant differences in smoking outcome expectancies exist between smokers with and without PTSD. Expectancies may be an important risk factor for maintenance of smoking in persons with PTSD.

Meaning of Hymen Perforation a Group of Sexual Abused Women in a Muslim Country

(Abstract #196485)

Poster # S-164 (Practice, Clin Res) **Exhibition Hall, 4th Floor**

Sezgin, Ufuk, PhD[1]; Yuksel, Sahika, MD[2]; Bikmaz, Sevda, MD[3]

[1]Kocaeli University, Istanbul, Turkey
[2]Istanbul University, Istanbul, Turkey
[3]Istanbul Medical Faculty, Istanbul, Turkey

Purpose: As a sexual relation before marriage is not accepted for the women by the society in Turkey, it is important to protect the hymen until marriage. For this reason hymen perforation has a special importance for women stigmatization. However for rape it does not make a difference in regarding psychological effects if the women's hymen perforated or not. Briefly it was not accepted that rape would cause severe psychological disorders in women in every condition.

Method: 80 women patients with a history of SA who were admitted to Istanbul Psychosocial Trauma Program were evaluated.

Findings: The patients were in between 15 - 65-years-old (mean 25.8+-10.27). Behaviour of own damage was seen in 67% of patients with hymen perforation and 43% of patients without hymen perforation. A relation was observed with hymen perforation and self mutilating behavior. There was no difference between two groups regarding their friend, parents and family relations, abnormality in functional levels, psychological problems after trauma and suicide thought.

Discussion: In this evaluation which was done in Turkey, the meaning of sexual trauma for women whose first sexual relations were SA and the importance of virginity will be discussed.

Poster # S-165 (withdrawn)

Poster # S-166 (withdrawn)

Poster # S-167 (withdrawn)

Predicting Adult PTSD Symptomatic Distress From Child Emotional Abuse and Post-Trauma Cognitions

(Abstract #196495)

Poster # S-168 (Assess Dx, Clin Res) **Exhibition Hall, 4th Floor**

Petretic, Patricia, PhD[1]; White, Elizabeth, BSC, BA[2]; Makin-Byrd, Lori, MA[3]; Limberg, Neal, MA[3]; Addison-Brown, Kristin, MA[3]; Jacobs, Ingrid, MA[3]

[1]Psychology, University of Arkansas at Fayetteville, Fayetteville, Arkansas, USA
[2]University of Arkansas, Farmington, Arkansas, USA
[3]Department of Psychology, University of Arkansas, Fayetteville, Arkansas, USA

This study evaluated the role of cognitive distortions in explaining PTSD and other forms of symptomatic distress in young adults who reported experiences of childhood emotional abuse victimization. Childhood physical, sexual, and emotional abuse experiences, cognitive distortions (CDS), and symptomatic distress (TSI) were assessed in a sample of 762 undergraduates in a study examining predictors of long-term outcome of childhood trauma experiences. A subsample of 192 participants reported childhood emotional abuse, either with or without co-morbid physical and/or sexual abuse. Clinically significant levels of self-blame, self-criticism, and preoccupation with danger were present in the multiple abuse and emotional abuse only groups compared to the physical abuse only and no abuse control groups. In the emotional abuse only group, self-critical cognitions predicted PTSD (e.g., defensive avoidance, intrusive experiences, anxious arousal, dissociation) symptoms, while self-blame predicted impaired sense of self (impaired self-reference) and maladaptive coping (tension-reducing behaviors). In the physical + emotional abuse group, cognitions that view the world as a dangerous place predicted PTSD symptoms of intrusive experiences and defensive avoidance), while multiple types of cognitive distortions predicted impaired self-reference and anxious arousal.

Dissociation, Metacognition, and Emotional Control in Students With Different Trauma Experiences

(Abstract #196496)

Poster # S-169 (Res Meth, Assess Dx) **Exhibition Hall, 4th Floor**

Barlow, M. Rose, PhD[1]; Goldsmith, Rachel E., PhD[2]

[1]Psychology, Boise State University, Boise, Idaho, USA
[2]Portland VA Medical Center, Portland, Oregon, USA

Dissociation is a common response to trauma, and has been associated with alexithymia. Trauma is also related to changes in information processing and emotion. However, previous research has not fully examined the impact of trauma on metacognitions, specifically, attempts to control one's own negative thoughts and to control difficult emotions. Several measures have been created to address alexithymia and attempts to regulate emotion. These measures include the TAS, the IES, measures by Lischetzke and Eid (2003), the MCQ-30 (Wells & Cartwright-Hatton, 2004), and the TCQ (Wells & Davies, 1994). Research is needed to establish the psychometric properties of several of these measures and the relations among their constructs and outcomes. The current study examined the relationships among dissociation, alexithymia, and regulation of cognition and emotion in a sample of college students with various trauma histories, as well as students with no reported history of trauma. Results demonstrate that these constructs are interrelated, yet tap different aspects of

metacognitive and emotional experiences. Findings are discussed in light of implications for posttraumatic cognition and emotion, and for future research.

Quality of Life and Symptom Cluster Severity Among Veterans With PTSD

(Abstract #196500)

Poster # S-170 (Clin Res, Mil Emer) **Exhibition Hall, 4th Floor**

Eggleston, Angela, PhD[1]; Calhoun, Patrick S., PhD[2]; Collie, Claire, PhD[3]; Beckham, Jean, PhD[2]; Yeatts, Beth P., MS[3]; Dennis, Michelle, BS[4]

[1]VA Mental Illness Research, Education, and Clinical Center, VISN6, Durham VA Medical Center, Durham, North Carolina, USA
[2]VA Mental Illness Research, Education, and Clinical Center, VISN6, Duke University and Durham Veterans Affairs Medical Centers, Durham, North Carolina, USA
[3]Durham Veteran Affairs Medical Center, Durham, North Carolina, USA
[4]Duke University and Durham Veteran Affairs Medical Center, Durham, North Carolina, USA

PTSD patients experience poorer subjective satisfaction and functioning (quality of life; QOL), than patients with chronic psychiatric or medical disorders and patients with other anxiety disorders. The relationship between QOL and symptom cluster severity has not been examined, however. Data were collected from clinician-referred veterans diagnosed with PTSD (N=571) during a standard diagnostic evaluation at a VA specialty PTSD clinic between June 2000 and August 2007. PTSD diagnosis was based on the Clinician-Administered PTSD Scale. Patients completed the Sheehan Disability Questionnaire and the Quality of Life Inventory during the standard clinical evaluation. Initial analyses show majority (76%) of veterans endorsed very low or low satisfaction scores and reported marked perceived stress (M=7.1, SD=2.7) and little perceived social support (M=35.3, SD=29.5). Subsequent analyses controlled for age and depression (BDI). PTSD severity predicted overall satisfaction scores and perceived stress (both $p<.05$), but not perceived social support ($p>.10$). All three symptom cluster severity ratings were related to perceived stress (all $p<.05$). Only the avoidance symptom cluster predicted overall satisfaction and perceived social support ($p<.01$). Targeting PTSD symptoms globally or avoidance symptoms specifically may provide more rapid subjective improvements.

Predictors of Adjustment to Sexual Assault Trauma

(Abstract #196503)

Poster # S-171 (Clin Res,Prev EI) **Exhibition Hall, 4th Floor**

Steenkamp, Maria, MA[1]; Salters-Pedneault, Kristalyn, PhD[2]; Conoscenti, Lauren, PhD[3]; Fuse, Tiffany, PhD[3]; Vine, Vera, BA[3]; Litz, Brett, PhD[4]

[1]Boston University, Boston, Massachusetts, USA
[2]National Center for PTSD, VA Boston Healthcare System, Jamaica Plain, Massachusetts, USA
[3]National Center for PTSD, Boston, Massachusetts, USA
[4]Psychiatry, VA Boston Healthcare System and Boston University, Boston, Massachusetts, USA

Although most sexual assault survivors recover effectively after an initial period of severe distress, there is evidence that those who fail to recover within several months of the event are at risk for chronic posttraumatic symptomatology. Studies examining predictors of chronic PTSD in this population have typically used cross-sectional designs, and little is known about adjustment to sexual assault over time. The present ongoing study, conducted collaboratively by the Boston VA and the Boston Area Rape Crisis Center, aims to examine predictors of chronic trauma-related symptomatology longitudinally in a group of recently sexually assaulted women. Women who have been assaulted within the past four weeks are asked to complete online questionnaires at four time points, obtained monthly within the first four months of the assault. Analyses will examine which PTSD symptoms and cognitive reactions in the acute phase after the trauma predict longer-term PTSD symptoms and impairment in functioning, using the PTSD Checklist-Civilian Version, the Depression Anxiety Stress Scale, the Posttraumatic Cognitions Inventory, and the Rape Attribution Questionnaire. Preliminary results indicate the presence of significant PTSD symptomatology across all time points, with mean PCL scores of 61.33 at Time 1; 51 at Time 2; 34.5 at Time 3; and 33.5 at Time 4.

Poster # S-172 (withdrawn)

Impact of Injury Description on Scar-Rated Cognitive Appraisals

(Abstract #196505)

Poster # S-173 (Clin Res, Ethics) **Exhibition Hall, 4th Floor**

Weaver, Terri, PhD[1]; Hinrichs, Jon, BS[2]; Howell, Meagan, MS[1]

[1]Psychology, Saint Louis University, Saint Louis, Missouri, USA

An estimated 1.5 million women experience intimate partner violence each year, 1/3 of whom experience some form of injury (Tjaden & Thoennes, 2000). Following such injury, residual marks or scars often result. Research shows that women with violence-related scars report significantly more negative perceptions of their scar than an observer (Weaver, Turner, Thayer, Schwarze, & Sand, 2007). The current study explores whether participants' perceptions of a scar's appearance are influenced by the method of injury resulting in the scar. Participants were randomly assigned to receive a fictional script describing an injury caused by intimate partner violence-related interactions versus accidental events, and violence as the direct versus an indirect cause of the scar. Participants then viewed a photograph of a scar and were asked to rate their perception of the scar's appearance using the Manchester Scar Assessment Proforma. The potential influence of race was also explored by digitally altering the existing scar so that one image represents an African American victim and one image a Caucasian victim. If perceptions differ depending on the injury-producing mechanism, race, or some interaction of these factors, such findings would support the importance of injury context as influencing resulting perceptions.

Contemporary Approaches to Behavioral Health in Fire and EMS Organizations

(Abstract #196507)

Poster # S-174 (Mil Emer,Prev EI) **Exhibition Hall, 4th Floor**

Gist, Richard, PhD[1]; Taylor, Vickie Harris, MSW[2]

[1]University of Missouri-Kansas City/Kansas City Fire Department, Kansas City, Missouri, USA
[2]National Fallen Firefighters Foundation, Emmitsburg, Maryland, USA

Recent advances in research and understanding of the behavioral health impacts of a fire or emergency medical services career have necessitated reconceptualization of previous approaches to prevention and intervention. A growing body of research has indicated limited efficacy for techniques based on critical incident stress debriefing while suggesting potential for paradoxical impacts on recovery of some recipients. Current recommendations focus on personal and organizational foundations that help to bolster resilience while ensuring appropriate screening and access to evidence based clinical intervention where indicated.

The National Fallen Firefighters Foundation (NFFF), as part of its mandate to reduce the impact of occupational fatality and injury among first responders, developed 16 Life Safety Initiatives in cooperation with leaders in industry, academic, and practice roles. Projects under its behavioral health initiative have focused on building consensus approaches for the organizations providing these essential community services and the professionals who provide care to their members. This workshop will provide overview of NFFF's behavioral health initiative, with particular

emphasis on recommendations regarding preparation, mitigation, screening, and intervention related to occupational exposures to potentially traumatic events.

Poster # S-175 (withdrawn)

From War to Asylum: Stress and Coping Behaviors of East African Refugees

(Abstract #196510)

Poster # S-176 (Civil Ref, Cul Div) **Exhibition Hall, 4th Floor**

Gavian, Margaret, MA[1]; Perera, Sulani, BA[1]; Frazier, Patricia, PhD[2]; Johnson, David, MD, MPH[3]; Spring, Marline, PhD[3]
[1]Psychology, University of Minnesota, Minneapolis, Minnesota, USA
[2]University of Minnesota, Minneapolis, Minnesota, USA
[3]Minneapolis VAMC, Minneapolis, Minnesota, USA

The purpose of this investigation was to determine the most stressful life events experienced, and the coping strategies used, by East African (Somali and Oromo) refugees (N = 535) living in Minnesota at three time periods: in their home countries, in transit and the US was not without stress. Language (28%), employment (13%) and housing (10%) difficulties were most frequently reported as most stressful. To cope with these stressors, participants made efforts to learn English (31%), and sought social (21%) or professional support (8%). Religious practices were a consistent coping strategy (12-14%) before resettlement but waned once participants arrived in the US. Gender and ethnic group (Somali vs. Oromo) differences will be explored.

Post-War Recovery – It's Not All About Losses

(Abstract #196511)

Poster # S-177 (Mil Emer,Prev El) **Exhibition Hall, 4th Floor**

Pierce, Penny, PhD[1]
[1]University of Michigan, Ann Arbor, Michigan, USA

Drawing on a recent reformulation of the stress and coping model known as Conservation of Resources (COR) theory (Hobfoll et al., 1988), we explored the relationship between gains and losses and health and functioning outcomes with a sample of Air force personnel serving in Operation Iraqi Freedom. Regression models explained 25 - 43 % of the explained variance in outcome scores; independent of demographics, military background and job-related stressor variables, COR theory constructs were significant predictors of depression symptoms (ÄR2 = 0.06***), PTSD symptoms (ÄR2 = 0.08***), role and emotional functioning (ÄR2 = 0.01**) and perceived physical health (ÄR2 = 0.03***). Greater depression symptoms were reported by those experiencing greater losses and gains during deployment (Stdz.Beta = 0.28*** and Stdz.Beta = 0.08*, respectively). Greater posttraumatic stress disorder (PTSD) symptoms were predicted by the experience of greater losses during deployment (Stdz.Beta = 0.35***); yet PTSD was unrelated to gains (Stdz.Beta = 0.03). Better physical health was more likely to be reported by those having fewer losses (Stdz.Beta = -0.20***) but perceived physical health was unrelated to gains (Stdz.Beta = 0.06). Finally, role and emotional functioning was higher for those reporting greater gains (Stdz.Beta = 0.07*) and fewer losses (Stdz.Beta = -0.07).

A Factor Analysis of the PDEQ From a Sample of Police Officers Following the WTC Attack

(Abstract #196514)

Poster # S-178 (Disaster, Res Meth) **Exhibition Hall, 4th Floor**

Henn-Haase, Clare, PsyD[1]; Metzler, Thomas, MA[1]; Best, Suzanne, PhD[2]; Neylan, Thomas, MD[1]; Marmar, Charles, MD[1]
[1]University of California San Francisco; Veterans Affairs Medical Center, San Francisco, California, USA
[2]Veterans Affairs Medical Center, San Francisco, California, USA

Brooks et al. (2008, in preparation) examined the factor structure of the Peritraumatic Dissociative Experiences Questionnaire, the most widely used measure of peritraumatic dissociation. Using exploratory factor analysis with promax rotation, they found two correlated factors: Lack of awareness and depersonalization/ derealization in a sample of accident victims. This study attempted to replicate these findings based on a cross-sectional sample of 725 police officers assessed prior to the attack on the WTC, and to determine if the two factors differentially predict subsequent PTSD symptoms measured using the PCL and SCL-90 in a subsample of 293 New York City police officers exposed to the WTC attack. The results essentially replicated the 2 factor structure, with a correlation between factors of .71, compared to .59 in Brooks et al. The 2 factors were equally correlated with subsequent PCL scores (r=.32 and .29) and SCL-90-GSI scores (r=.28 and .26). A single factor PDEQ score predicted nearly identically (r=.30 and .27 for PCL and SCL-90-GSI, respectively). Because the two factors are highly correlated with each other and do not differentially predict symptom outcomes, there appears to be no compelling evidence to support measuring peritraumatic dissociation using two factors.

Vicarious Trauma Exposure, Community Violence Exposure, and PTSD Among Guatemalan Aid Workers

(Abstract #196515)

Poster # S-179 (Cul Div, Civil Ref) **Exhibition Hall, 4th Floor**

Roberts, Rebecca, MA[1]; Cree, Emily, MA[1]; Gallegos, Autumn, MA[1]; Potts, Amy, MA[1]; Putman, Katharine, PsyD[1]; Foy, David W., PhD[2]
[1]Fuller Graduate School of Psychology, Pasadena, California, USA
[2]Pepperdine University Graduate School of Psychology, Encino, California, USA

Studies have identified aid workers as being at risk for both direct personal exposure and vicarious exposure to traumatic events as result of working with traumatized individuals in often dangerous locales (Eriksson, 2001). The current study explored personal and vicarious trauma exposure and the number of children a worker serves in relation to negative symptomatology among teachers and aid workers at 2 NGOs in Guatemala. Workers reported that they knew about an average of 9.54 traumatic events (SD = 4.97) that the children they served experienced, including being beaten up or robbed, seeing a dead body, being asked to use drugs, being raped, or being ill. Personal exposure to violence for the workers was positively related to vicarious exposure through hearing children's stories of violence, a reflection of the overall legacy of violence for the country. Nineteen percent of workers met criteria for a PTSD diagnosis, and another 26% had clinically significant symptoms. A higher number of children on a worker's caseload was significantly related to worker PTSD, though not in the predicted direction; teachers with fewer students are likely to have closer relationships with them, which may put the workers more at risk for vicarious exposure.

Occupational Functioning and PTSD in Women With Military Service Experience

(Abstract #196517)

Poster # S-180 (Clin Res, Mil Emer) **Exhibition Hall, 4th Floor**

Schnurr, Paula, PhD[1]; Lunney, Carole, MA[1]; Marx, Brian, PhD[2]
[1]National Center for PTSD, White River Junction, Vermont, USA
[2]National Center for PTSD, Boston, Massachusetts, USA

Concerns about substantial increases in PTSD disability claims by veterans have heightened the need for knowledge about occupational functioning among veterans with PTSD. To further understanding of the topic, we used data from 284 female veterans and active duty personnel who participated in a randomized clinical trial of psychotherapy for PTSD. Our first objective was to examine the relationship between PTSD symptom clusters and occupational functioning, operationalized as work-related quality of life (QoL) and clinician-rated occupational impairment. Our second objective was to examine how changes in PTSD symptom clusters relate to changes in occupational functioning. Analyses are ongoing. Initial analyses show that, as expected, veterans who were not working had greater occupational impairment relative to those working full- or part-time. Similarly, veterans with disability ratings of 50% had greater impairment relative to participants with lower disability ratings or those who had never applied. Veterans who were not working had lower work-related QoL than those who were retired or working. There were no differences in work-related QoL among disability groups. All symptom clusters uniquely contributed to predicting occupational impairment, but only numbing symptoms uniquely predicted work-related QoL. Implications for treatment will be discussed.

Poster # S-181 (withdrawn)

Posttraumatic Stress Disorder Symptoms Associated With Abuse in College Relationships

(Abstract #196520)

Poster # S-182 (Clin Res,Prev El) **Exhibition Hall, 4th Floor**

Avant, Elizabeth, BS[1]; Davis, Joanne, PhD[1]; Elhai, Jon, PhD[2]
[1]University of Tulsa, Tulsa, Oklahoma, USA
[2]University of South Dakota, Vermillion, South Dakota, USA

Previous research has compared symptoms of posttraumatic stress disorder (PTSD) with physical, sexual, and psychological abuse in intimate relationships among treatment/help-seeking women. The results suggest that psychological abuse was a significant predictor of PTSD symptoms while other forms of abuse were not (Dutton, Goodman, & Bennett, 1999; Taft, Murphy, King, Dedeyn, & Musser, 2005). However, no previous study has evaluated this relationship in a college sample. Thus, this study was designed to compare PTSD symptoms associated with physical, sexual, and psychological abuse in intimate relationships among college students. The sample included 49 college men and women who answered a web based survey comprised of the following measures: Revised Conflict Tactics Scale (Straus, Hamby, Boney-McCoy, & Sugarman, 1996), Modified PTSD Symptom Scale (Falsetti, Resnick, Resick, & Kilpatrick, 1993), and Trauma Assessment for Adults (Resnick, Best, Freedy, Kilpatrick, & Falsetti, 1993). In contrast to previous findings, multiple regression analyses indicated no significant relationships between the three types of abuse and PTSD symptoms. These results may reflect a difference between a college population and other populations that may report more severe abuse and/or more severe PTSD symptoms. Thus, further research including a college population is needed.

Daily PTSD Symptom Presentation in Individuals With and Without Major Depressive Disorder

(Abstract #196521)

Poster # S-183 (Assess Dx, Res Meth) **Exhibition Hall, 4th Floor**

Slagle, David, PhD[1]; Bittinger, Joyce, MS[1]; Parker-Maloney, Kelly, BA[1]; Fabritius, Jennifer S., BA[2]; McDavid, Joshua, MD[1]; Zoellner, Lori, PhD[1]
[1]University of Washington, Seattle, Washington, USA
[2]Case Western Reserve University, Cleveland, Ohio, USA

The frequent co-occurrence of major depressive disorder (MDD) with posttraumatic stress disorder (PTSD) has been well established in the literature by the use of measures that evaluate PTSD retrospectively. Retrospective methods, however, have offered little insight into daily PTSD symptom presentation among those with comorbid MDD compared to those without depression. The immediate research sought to better understand the daily PTSD symptom presentation among those with and without co-occurring MDD. A sample of 89 adults entering a randomized clinical trail with a primary diagnosis of PTSD monitored daily PTSD symptoms using the Posttraumatic Stress Scale-Self Report over seven days prior to treatment. Individuals with PTSD+MDD reported greater overall PTSD symptom severity relative those with PTSD only (d = .73). Moreover, those with PTSD+MDD endorsed greater re-experiencing (d = .50), avoidance/numbing (d = .76), and hyperarousal (d = .61) symptoms relative to those with PTSD. In contrast to research using retrospective methods (e.g., Shalev et al., 1998), daily monitoring demonstrated that those with PTSD+MDD experienced greater symptom severity in all symptom clusters over time relative to those without depression. Retrospective methods may not completely capture clinical differences and use of daily evaluation may offer a more refined clinical picture.

Adult Children of Domestic Violence: Psychobiological Correlates in Victims of Domestic Violence

(Abstract #196522)

Poster # S-184 (Assess Dx, Bio Med) **Exhibition Hall, 4th Floor**

Pinna, Keri, MA[1]; Johnson, Dawn, PhD[2]; Delahanty, Doug, PhD[1]
[1]Kent State University, Kent, Ohio, USA
[2]Summa Kent State Center for the Treatment and Study of Traumatic Stress, Akron, Ohio, USA

Exposure to domestic violence (DV) is a specific type of trauma history that is typically not assessed for in traditional trauma history questionnaires. Further, little is known about the long-term effects of exposure to domestic violence during childhood. The present report seeks to provide preliminary data to remediate this deficit in the literature. Psychobiological characteristics were examined in a sample of women currently residing in battered women's shelters. A number of differences were identified between women reporting a history of exposure to DV and those denying such a history. Women endorsing a history of exposure had higher rates of Bipolar Disorder, more severe symptoms of PTSD, earlier age of first trauma, and a greater number of interpersonal traumas and childhood sexual abuse. Differences were also noted in the extent to which cortisol activity was associated with symptoms of PTSD between groups. Results suggest the importance of specifically accounting for exposure to DV during childhood during assessment of trauma history, and provide preliminary results characterizing adult children of domestic violence.

Perceived Social Support and Distress Among Tibetan Survivors of Torture and Refugee Trauma

(Abstract #196525)

Poster # S-185 (Civil Ref, Cul Div) **Exhi Exhibition Hall, 4th Floor**

Lhewa, Dechen, MA[1]; Rosenfeld, Barry, PhD[2]
[1]Boston University, Boston, Massachusetts, USA
[2]Fordham University, New York, New York, USA

Research on social support and psychological distress indicate that greater social support is associated with less psychological distress. There is a lack of literature on this relationship among traumatized Asian populations. This study sought to examine the relationship between social support and psychological distress among Tibetan survivors of torture and refugee trauma living in New York City. The Multidimensional Scale of Perceived Social Support (MSPSS) and the Brief Symptom Inventory-18 (BSI-18) were translated and back-translated by college educated Tibetan professionals. All 57 adult participants were administered the two questionnaires as a part of a larger battery assessing for coping and distress. Preliminary analysis show that there was a significant negative correlation between total perceived social support and psychological distress ($r(55) = -.271$, $p < .05$). There was also a significant negative correlation between perceived social support from friends and psychological distress ($r(55) = -.319$, $p < .05$). There were no significant correlations between perceived social support from family members or 'significant others' and psychological distress. The findings will be discussed.

Poster # S-186 (withdrawn)

Why Some Women Do Not "Grow" After Surviving Intimate Partner Violence

(Abstract #196528)

Poster # S-187 (Clin Res, Res Meth) **Exhibition Hall, 4th Floor**

Kelso, Lauren, BA[1]; Fiore, Christine, PhD[2]; Legerski, Joanna, MA[2]; Skinner, Sabrina, BA[2]
[1]Psychology, The University of Montana, Missoula, Montana, USA
[2]University of Montana, Missoula, Montana, USA

Struggling with very stressful and challenging circumstances does not always have a negative outcome, and the positive beneficial change that comes from this is described as posttraumatic growth (Calhoun & Tedeschi, 1998). The purpose of this poster is to explore possible reasons why some survivors of intimate partner violence (IPV) do not experience any resilience or posttraumatic growth after the ending of their violent relationship. In a recent qualitative study (Young, 2007), 8 out of 135 women who were survivors of IPV and had been out of their violent relationship for at least 1 year were found to have not shown any signs indicative of resilience or posttraumatic growth. Using Strauss and Corbin's (1990) grounded theory, the current study explored possible reasons why the 8 women from Young's (2007) study did not evidence any resilience or posttraumatic growth. Qualitative analysis revealed that during their violent relationship, 6 out of the 8 women experienced partner infidelity. In addition to surviving their violent relationship, the infidelity the women experienced may have been a barrier to resilience or posttraumatic growth. Findings will be discussed in the context of existing theories on resilience and posttraumatic growth following intimate partner violence.

Assessing Clinical Staff Members' Cultural Competence in a Traumatic Stress Training Program

(Abstract #196530)

Poster # S-188 (Cul Div, Media) **Exhibition Hall, 4th Floor**

Whealin, Julia, PhD[1]; Aosved, Allison, PhD[2]
[1]National Center for PTSD, Honolulu, Hawaii, USA
[2]Pacific Islands Health Care System, Department of Veteran Affairs, Honolulu, Hawaii, USA

Cultural competence refers to the knowledge, skills, and attitudes that are required to work effectively across diverse groups. As part of a broader program evaluation for cultural competency, clinical supervisors (N=7) in a multidisciplinary trauma training program completed the Staff Cultural Assessment Inventory (SCAI; Whealin and Aosved, 2007), a survey that assesses staff's cultural training, knowledge, and clinical practices. Results showed that staff received training in cultural competency at least yearly and sought out additional education on their own, for example, by reading cultural and/or professional literature. Moreover, the majority of staff spent free time with people who differed from them culturally and participated in the cultural events of diverse groups. Supervisors were able to identify the major client demographic subgroups, and reported that they incorporate cultural factors into their interventions. However, only a portion (57%) reported that they regularly incorporate cross-cultural factors in assessment or assessed whether clients have had past experience with discrimination or racism. Results of the evaluation helped identify discrepancies in cross cultural care and targeted behavioral goals for future training. This poster will discuss the benefits and limitations of this evaluation and copies of the SCAI tool will be provided.

An Examination of Risk Factors for Chronic Dating Violence in a College Population

(Abstract #196535)

Poster # S-189 (Clin Res,Prev El) **Exhibition Hall, 4th Floor**

Ghimire, Devika, BA[1]; Follette, Victoria, PhD[1]; Clark, Nick, HSCD[1]
[1]University of Nevada Reno, Reno, Nevada, USA

Research indicates that survivors of childhood abuse are significantly more likely to be revictimized, including in dating relationships (Stets & Pirog Good, 1989). However, the distinguishing characteristics of revictimized and non-revictimized individuals are not clearly understood (Few & Rosen, 2005), especially as they relate to individuals who remain in chronic violent dating relationships. The goal of the current study is to better understand risk factors for experiencing dating violence, especially chronic dating violence, among those with and without a history of physical and/or sexual childhood abuse. To this end, a constellation of variables that have not been extensively studied within this population will be investigated. Avoidance, emotion regulation, alcohol use, and self-blame will be assessed in approximately 300 college students. It is hypothesized that greater levels of avoidance, difficulties in emotion regulation, alcohol use, and self-blame will differentiate revictimized from non-revictimized individuals. By identifying features of victims' repertoire in dating violence, this study will provide a theoretical background to the understanding of relationship violence. Increased knowledge about risk factors for experiencing dating violence is expected to have important implications for the prevention of chronic dating violence.

Examining the Relationship of Resilience and Symptomatic Distress

(Abstract #196538)

Poster # S-190 (Clin Res, Assess Dx) **Exhibition Hall, 4th Floor**

White, Elizabeth, BSC, BA[1]; Petretic, Patricia, PhD[2]
[1]University of Arkansas, Farmington, Arkansas, USA
[2]University of Arkansas, Fayetteville, Arkansas, USA

Resilience is widely defined as the ability of individuals to achieve an adaptive and relatively positive outcome, either in the face of adversity or following an adverse and highly stressful life event. While there is often a range of reactions displayed following trauma that fall along a continuum of positive and negative outcomes in terms of adaptive functioning and symptomology, resilience is considered to be among the most positive outcomes following trauma. Most conceptualizations of resilience broadly view the construct as a possession of multiple positive coping characteristics that are utilized to overcome the negative impact of trauma. An assumption exists that these coping mechanisms will prevent the development of pathological symptoms. However, there has been little investigation of the symptomatic presentation of resilient individuals. The study hypothesizes that those who display high resilience will show less distress and pathological symptomology following trauma. Relations between scores of resilience (CD-RISC) and trauma symptomology (TSI) will be examined to determine if lower symptomatic distress is indeed associated with higher resilience.

Relationship Between Religious Coping and PTSD Symptoms Among Firefighter Recruits

(Abstract #196539)

Poster # S-191 (Mil Emer, Cul Div) **Exhibition Hall, 4th Floor**

Meyer, David, PhD[1]; Smith, Lisa M., BS[1]; McNeill, Shannon, BS[1]; Liverant, Gabrielle, PhD[1]; Kamholz, Barbara, PhD[1]; Gulliver, Suzy, PhD[2]
[1]Psychology, VA Boston Healthcare System/Boston University, Boston, Massachusetts, USA
[2]VISN 17 Center of Excellence for Research on Returning War Veterans/Texas A&M College of Medicine, Waco, Texas, USA

Firefighters are exposed to potentially traumatic events throughout their careers. for some, pre-existing risk factors and coping strategies can increase vulnerability for the development of psychopathology. Others will show resilience, which is defined as "the ability to maintain a stable equilibrium" (Bonanno, 2004; p. 20). Previous research suggests that religious coping may promote posttraumatic growth and serve as a protective factor against the development of trauma related symptoms (Shaw, et al, 2005). Measurement of religious coping typically involves assessment of both religious belief and engagement in religious or ritualistic behaviors (Carver, et al, 1989). This presentation explores the relationship between these different aspects of religious coping and self-reported symptoms of PTSD in firefighter recruits. Approximately 200 firefighter recruits, from six professional fire departments, were sampled as part of a prospective longitudinal study following recruits through the first three years in fire service. Discussion focuses on the relationship between religious belief and religious behavior and PTSD symptoms over time. These findings advance our basic understanding of the characteristics of individuals enrolled in the fire academy as well as the relationship between religious coping, psychopathology, and resilience in emergency responders.

Disgust in PTSD and its Affect on Autonomic Functioning

(Abstract #196540)

Poster # S-192 (Bio Med, Clin Res) **Exhibition Hall, 4th Floor**

Grooms, Amy, BA[1]; Smith, Rose C., BA[1]; Bown, Stevie, BA[1]; Feldner, Matthew T., BA, PhD[1]
[1]University of Arkansas, Fayetteville, Arkansas, USA

Elevated disgust has been linked to posttraumatic stress disorder (Fairweather & Rachman, 2004; Foy et al., 1984). Disgust-based affective reactions to emotion-evoking stimuli also have been associated with decreased sympathetic, and increased parasympathetic, system activity (Rohrmann & Hopp, 2008). Based on this literature we currently are testing the relation between laboratory-based disgust reactions to individualized traumatic event cues and both parasympathetic and sympathetic system reactivity. It is hypothesized that participants the level of disgust elicited during exposure to traumatic event cues among people with PTSD will positively relate to level of parasympathetic responses and negatively relate to level of sympathetic responses to the event cues. Sympathetic and parasympathetic activity is being measured via continuous measurement of the low and high frequency components of heart rate variability, respectively, prior to, during and after the guided imagery task. Although data collection is ongoing (with an expected completion date of 6-1-08), preliminary analyses are consistent with hypotheses.

The Impact of War on the Marriage: Development of a Therapy Group for Spouses of Veterans With PTSD

(Abstract #196541)

Poster # S-193 (Mil Emer, Practice) **Exhibition Hall, 4th Floor**

Reck, Jennifer, MS[1]; Bender, Steven, PhD[2]; Ryan, Linda, MSW[2]
[1]Department of Psychology, University of North Texas, Denton, Texas, USA
[2]Sam Rayburn Memorial Veterans Center, Bonham, Texas, USA

Soldiers returning from the Iraq War are experiencing high levels of interpersonal and relationship problems. Such evidence underscores the impact of PTSD and other mental health problems on the soldiers' spouses and family (Milliken, Auchterlonie, & Hoge, 2007). Research with partners of veterans with PTSD has indicated that many partners exhibit high levels of psychological distress, marital discord, caregiver burden, and secondary PTSD symptoms (Manguno-Mire et al., 2007). Recent studies assessing the needs of veterans with combat-related PTSD and their families have indicated that one of the most requested services is a women-only group or wives' group (Sherman et al., 2005). The current study focuses on the development of an eight-week group therapy for spouses of veterans with PTSD. The group utilizes both psychoeducational and process components, and topics covered in the group include secondary traumatization, marital communication, intimacy, self-care skills, assertiveness, anger, and stress management. A summary of group demographics and individual sessions will be presented. in addition, preliminary outcome findings will be presented regarding PTSD symptoms, quality of life, marital functioning, and caregiver burden. Implications for the treatment of veterans with PTSD and their families will be discussed, along with suggestions for future research.

PTSD as a Prospective Mediator of Sexual Revictimization Among College Females

(Abstract #196542)

Poster # S-194 (Assess Dx, Res Meth) **Exhibition Hall, 4th Floor**

Hattula, Mandy, MA[1]; Varkovitzky, Ruth, BS[1]; Orcutt, Holly, PhD[1]
[1]Northern Illinois University, De Kalb, Illinois, USA

Theory and research suggest that posttraumatic stress disorder (PTSD) may mediate the relationship between childhood sexual abuse (CSA) and adult sexual assault (ASA). Recent research suggests that of the three PTSD symptom clusters (reexperiencing, avoidance, and hyperarousal), only hyperarousal mediates the relationship between CSA and ASA. However, these findings were based on a cross-sectional investigation. The present study explores the mediational role of PTSD symptoms in a prospective sample of undergraduate females. Two waves of data were collected from 702 females, 12 of whom reported sexual assault during the course of the study. Time 1 PTSD symptoms were used in analyses. Two structural equation models were proposed. The first model included total PTSD symptoms as a mediator, while the second model examined the 3 PTSD symptom clusters. Consistent with previous research, CSA reported at Time 1 was predictive of prospective sexual assault. CSA also predicted Time 1 PTSD symptoms. Time 1 PTSD symptoms, however, were not related to prospective sexual assault, and thus did not mediate the relationship between CSA and ASA. At the cluster level, CSA was significantly related to each of the 3 PTSD symptom clusters; however, none of the 3 PTSD symptom clusters was predictive of ASA.

Assessment of Psychophysiological Reactions to Traumatic Events

(Abstract #196544)

Poster # S-195 (Assess Dx, Practice) **Exhibition Hall, 4th Floor**

Fortson, Beverly, PhD[1]; Tunno, Angela, BA[1]; Moseley, Colby, BA[1]; Ansley, Stephanie, BA[1]
[1]Department of Psychology, University of South Carolina-Aiken, Aiken, South Carolina, USA

Prior research has documented the heightened psychophysiological arousal (i.e., increased heart rate and skin conductance) that occurs in those individuals with posttraumatic stress disorder (PTSD) when presented with cues related to their traumatic event (e.g., sounds, visual reminders). Other research suggests that individuals with PTSD can be distinguished from non-PTSD individuals due to the heightened psychophysiological reactivity to these reminders. Fifty undergraduate students (ranging in age from 18-22) were recruited for the current study. Participants completed an assessment of their exposure to 18 traumatic events prior to the heart rate and skin conductance assessments. As part of this assessment, participants reported on the time of the trauma exposure (<1 month ago, 1 month to 1 year ago, and >1 year ago) and their current distress level with regard to the event. Participants then watched a 40-minute video series of traumatic events for which they may have been exposed while heart rate, skin conductance, and subjective units of distress scale (SUDS) ratings were assessed. Analyses will examine whether those individuals with PTSD can be distinguished from those without PTSD and to assess the relation between self-report of distress and psychophysiological reactions to traumatic events.

Language of Secondary Traumatic Stress Found in Nonprofit, National Workers in Guatemala

(Abstract #196545)

Poster # S-196 (Cul Div, Commun) **Exhibition Hall, 4th Floor**

Cree, Emily, MA[1]; Roberts, Rebecca, MA[2]; Meese Putman, Katherine, PsyD[2]; Eriksson, Cynthia B., PhD, PhD[2]
[1]Fuller School of Psychology, Monrovia, California, USA
[2]Fuller School of Psychology, Pasadena, California, USA

The field of psychology is developing a greater focus on the effect of trauma work on those in helping positions. Though this field of research is growing, minimal studies have been done to determine the cultural nuances of these terms for those working in developing countries. This study will utilize transcripts of qualitative focus groups of 26 volunteers, administrators, and teachers in a nonprofit organization serving children and families in Guatemala's city dump. These groups discussed what they felt qualified as child sexual abuse (CSA). This study examined these transcripts in order to determine whether language of secondary traumatic stress (STS) was evidenced and if any cultural nuances exist to explain how they might be effected by working with a high-risk population. Consensual qualitative research (CQR) was used to develop common themes between vicarious trauma, compassion fatigue and other similar terms in order to build a better understanding of the definition of STS and how the transcript material might fit into those categories. Implications will be discussed categorizing statements into the following areas: Exposure to direct or vicarious trauma, statements of empathy and/or identification, PTSD symptoms statements and/or distress statements, risk factors, and unique cultural statements.

Witnessing Domestic Violence May Affect White Matter Integrity in Visual Perception Pathways

(Abstract #196548)

Poster # S-197 (Bio Med, Child) **Exhibition Hall, 4th Floor**

Teicher, Martin, MD, PhD[1]; Choi, Jeewook, MD, PhD[2]; Rohan, Michael, PhD(C)[1]; Polcari, Ann, RN, PhD[2]
[1]Harvard University, Belmont, Massachusetts, USA
[2]Harvard Medical School/McLean Hospital, Belmont, Massachusetts, USA

The aim of this study was to ascertain if witnessing domestic violence during childhood affected brain white matter (WM) tract development using MR Diffusion Tensor Imaging (DTI). 1402 volunteers were screened to recruit 20 carefully-selected subjects who witness domestic violence but were exposed to no other forms of trauma (16F/4M, 22.4Ò2.48 yrs) and 27 healthy control (19F/8M, 21.9±1.97 yrs). DTI images were acquired with a 3T Siemens Trio scanner and analyzed using Tract-Based Spatial Statistics (TBSS). Fractional anisotropy (FA) values in skeletonized white matter of left lateral occipital lobe (inferior longitudinal fasciculus) were significantly lower ($p<0.05$, corrected for multiple comparison) in domestic violence group even after controlling for parent's education, perceived childhood economic status, total IQ and exposure to parental verbal abuse. FA values in this region were significantly associated with ratings of depression, anxiety, somatization, and dissociation ($r=-0.502$, $p<0.001$; $r=-0.421$, $p=0.003$; $r=-0.377$, $p=0.01$; $r=-0.365$, $p=0.012$). The inferior longitudinal fasciculus connects occipital and temporal cortex, and is the main component of the visual-limbic pathway that subserves emotional, learning and memory functions that are modality specific to vision.

Poster # S-198 (withdrawn)

Domestic Violence History and Attempts to Leave Batterers as Predictors of Violence Severity

(Abstract #196553)

Poster # S-199 (Clin Res,Prev EI) **Exhibition Hall, 4th Floor**

Shin, Hana, MA[1]; Ross, Leslie, PsyD[1]; Yeh, Dow-Ann, BA[1]; Foy, Patrick, BA[1]; Foy, David, PhD[2]

[1]Children's Institute, Inc., Los Angeles, California, USA
[2]Pepperdine University, Encino, California, USA

Research has shown that history of domestic violence (DV) and attempts to leave the batterer are predictors for severity of violence and continued abuse. The current study included 341 DV victims receiving acute care from crisis intervention specialists accompanying law enforcement responders in inner-city Los Angeles. The objective of the current study was to explore the prevalence of DV in the sample and predictors for frequency and severity of violence. Regression analyses examined the effects of the number of prior DV incidents with the current batterer and prior attempts to leave on the reported frequency of physical and psychological abuse in the relationship. Results significantly indicated that the number of prior DV incidents with the current batterer and number of prior attempts to leave predicted the frequency of physical violence, B= -.33, $t(316) = 10.86$, $p < .01$, 95%CI = [0.27, 0.39]. The two factors also were found to significantly predict the frequency of psychological abuse, B = -.23, $t(316) = 8.63$, $p < .01$, 95%CI = [0.18, 0.29]. These results inform and improve prevention and intervention efforts for service providers and law enforcement responders about the risk factors for adult DV victims and their children.

Meditation Homework Adherence in PTSD Treatment

(Abstract #196558)

Poster # S-200 (Clin Res, Practice) **Exhibition Hall, 4th Floor**

Waelde, Lynn, PhD[1]; Uddo, Madeline, PhD[2]; Estupinian, Ginny, BA[1]; Mortensen, Mary Jo, BA[1]; Kukreja, Suniti, BA[1]; Masse, Jenni, BA[1] Spannring, Jeanna; Zief, Adi[1]

[1]Pacific Graduate School of Psychology, Redwood City, California, USA
[2]Southeast Louisiana VA Healthcare System, New Orleans, Louisiana, USA

Meditation interventions involve between-session practice of the techniques, yet there is little information about the types and intensity of homework adherence and relationships between adherence and outcomes. Daily sitting meditation practice and practice in daily life are important components of the Inner Resources meditation intervention, with the target adherence goal set at 180 minutes a week of sitting practice. The current paper will present adherence data from our one sample pilot studies of meditation for combat veterans and for Hurricane Katrina survivors. Analyses of participants' daily logs of homework practice indicate that minutes of practice per week increases across successive weeks in the intervention. At follow-up, most participants show continued adherence to daily practice. The use of meditation during stressful moments was associated with increased satisfaction with the program and increased adherence. Across studies, degree of homework adherence is associated with better treatment outcomes. Thus, despite the demanding nature of this homework regimen, participants have demonstrated a high degree of ongoing adherence to the homework and have tended to benefit more with greater levels of meditation practice.

The Relationship Between Physical Abuse, Experiential Avoidance and Sexual Revictimization

(Abstract #196559)

Poster # S-201 (Clin Res,Prev EI) **Exhibition Hall, 4th Floor**

Vijay, Aditi, MED[1]; Follette, Victoria, PhD[1]

[1]University of Nevada Reno, Reno, Nevada, USA

The literature indicates that there is a high prevalence of physical abuse, in conjunction with child sexual abuse and that is correlated with sexual revictimization. There is evidence to suggest that physical abuse is a strong predictor of revictimization (Cloitre & Rosenberg, 2006). While sexual revictimization has been studied extensively there is no conclusive evidence to indicate specific factors that are predictive of future victimization (Breitenbecher, 2001). Experiential avoidance is the unwillingness to remain in contact with unpleasant thoughts, feelings or emotions (Hayes, Wilson, Gifford, Follette & Strosahl, 1996). It is possible that increased rates of physical abuse are correlated with increases in experiential avoidance and sexual victimization.
This study investigates experiential avoidance and physical abuse as possible mediators of sexual revictimization through an Emotion Stroop task, the Acceptance and Action Questionnaire and the Conflict Tactics Scale. We hypothesize that higher rates of experiential avoidance and higher rates of physical abuse are correlated with increased incidents of sexual victimization. This poster will present correlational data and a regression analysis from a sample of 120 women (N=120) with a history of CSA, revictimized women and women with no history of sexual victimization.

The Clinical Correlates of Reported Childhood Sexual Abuse

(Abstract #196571)

Poster # S-202 (Clin Res, Child) **Exhibition Hall, 4th Floor**

Schoedl, Aline, MCS[1]; Pupo, Mariana, MCS[1]; Mello, Marcelo, PhD[1]; Mari, Jair J., PhD[1]

[1]Universidade Federal de Sao Paulo, Sao Paulo, Brazil

Background: The experience of early adversity is an important risk factor for the development of posttraumatic stress disorder (PTSD) and/or major depressive (MDD) during adulthood. Aims: The main aim of this paper was to investigate the relationship between the age of occurrence of reported sexual abuse and the development of PTSD and/or depressive symptoms during adulthood.

Methods: Seventy-nine outpatients were evaluated for the presence of PTSD and/or depressive symptoms. After consent, all patients were administered a standardized diagnostic interview, and 60 were found to meet *DSM-IV* criteria for a diagnosis of PTSD. These patients were evaluated for a reported history of sexual abuse before the age of 18 with the the Early Trauma Inventory (ETI), the Clinician-Administered Posttraumatic Stress Scale (CAPS), and the Beck Depression Inventory (BDI).

Results: Twenty-nine patients (48%) reported a history of sexual abuse before the age of 18. Relative risk (RR) of having severe PTSD symptoms was 10 times higher in patients reporting sexual abuse after age 12 than in those reporting sexual abuse before age 12. Conversely, RR of having severe depressive symptoms was higher for those reporting sexual abuse before age 12 than for those reporting such abuse after age 12.

Trauma Recovery, Remission and Resolution: Definitions, Differentiation and Measurement

(Abstract #196578)

Poster # S-203 (Res Meth, Assess Dx) **Exhibition Hall, 4th Floor**

Fenster, Juliane, MPH[1]; Park, Crystal, PhD[2]; Sarfo-Mensah, Abena, Undergraduate[2]; Lam, Jonathan, BA[2]

[1]Psychology, University of Connecticut, Bloomfield, Connecticut, USA
[2]University of Connecticut, Storrs, Connecticut, USA

Interest in PTSD and trauma recovery has increased recently, as armed service members have been faced with "sustained ground combat" for the first time since the Vietnam War, because members have been sent for multiple tours of duty, and these individuals are seeking mental health treatment in record numbers (Regan et al., 2006; p. 40). Researchers have also shared an interest in understanding the concepts of resolution, remission and recovery, however these terms have been used interchangebly and clear distinctions have not been made. For example, is the resolution of trauma just the absence of PTSD symptoms? To confuse matters even more, mulitple definitions of each construct may exist. For example, resolution has been defined as the modification or accommodation of one's schema system (Roth & Newman, 1993) or as a change in the symptoms of intrusions and avoidance (Lutgendorf & Antoni, 1999). The purpose of this presentation is to review the definitions of trauma resolution offered by various theoretical perspectives and then integrate them into a new definitional framework of resolution, recovery, and remission. We will illustrate how this framework helps to make sense of trauma-related phenomena and demonstrate the utility of a new self-report measure of trauma resolution.

Children in Disasters: Understanding Attachment Trauma of Gujarati Children

(Abstract #196582)

Poster # S-204 (Child, Disaster) **Exhibition Hall, 4th Floor**

Kumar, Manasi, PhD[1]; Fonagy, Peter, PhD[2]

[1]Psychology, University College London, London, United Kingdom
[2]Psychology, UCL, London, United Kingdom

Attachment trauma of children affected by the earthquake and riots in Gujarat in 2001-02 is studied. Attachment trauma can be defined as injury, separation, illness, death or other disruption of the primary caretaking relationship that significantly disrupts a child's expectation of being cared about and looked after adequately by a caretaking adult. Natural disasters and instances of social violence are precursors not only social to unrest but also to tremendous long-lasting psychological distress in children. The paper first evaluates recent disaster psychology literature to illuminate prominent mental health implications for young survivors of extreme trauma and disasters. Then, it highlights how post-disaster concerns for child and adolescent mental health are relatively underdeveloped and underreported in the worldwide disaster literature. Third, the paper raises methodological and theoretical debates associated with working with children in disasters in developing countries. Video-recorded Child Attachment Interviews provide insights into attachment-related issues and highlight various manifestations of trauma following the two events. The research is interested in knowing whether the nature of the trauma impacts differentially on the child's attachment representations. Few case studies on the nature of attachment trauma are presented here.

Reintegration of Returning Veterans and Families by Networking of Military and Community Resources

(Abstract #196604)

Poster # S-205 (Mil Emer, Commun) **Exhibition Hall, 4th Floor**

Wang, Paul, MDIV,, PhD[1]; Feder, Joel, DO[2]; Jerome, Jon, BA, BS[3]; Bobrow, Joseph, PhD[4]; Romberg, Barbara, PhD[5]

[1]U.S. Navy, Chesterfield, Missouri, USA
[2]U.S. Navy, Overland Park, Kansas, USA
[3]Operation Homefront, High Ridge, Missouri, USA
[4]Coming Home Project, San Francisco, California, USA
[5]Give An Hour, Bethesda, Maryland, USA

Reintegration of Returning Veterans and Families by Networking of Military and Community Resources Thirty to forty nine percent of U.S. troops returning from the Iraq war have developed stress-related mental health problems three to four months after coming home. The highest risk groups are the returning reservists who are returned to civilian life without access to nearby military resources. Secondary trauma to spouses and children has often been overlooked. A national strategy for preventing, mitigating, and alleviating psychological, moral, and spiritual injury through unit cohesion training, peer mentoring, and family support programs synergizing the military with existing community resources on a national scale has been developed to meet the overwhelming challenges ahead. The comprehensive program provides psychological, moral, and spiritual support and emergency assistance to servicemembers and their families during all phases of the deployment cycle, including up to two years following demobilization. The national strategy also includes caring for our wounded warriors and their families.

Subjective Experience of Traumatic Events: Later Adjustment & Sympathetic Reactivity

(Abstract #196609)

Poster # S-206 (Child, Bio Med) **Exhibition Hall, 4th Floor**

Arcus, Doreen, PhD[1]

[1]Psychology, Universit of Massachusetts Lowell, Lowell, Massachusetts, USA

Students (N = 103) in an urban university were asked to complete questionnaires describing (a) adjustment to college life (SACQ; Baker & Siryk,1989), and (b) history of traumatic events (TEs; related to crime, physical and sexual abuse, and natural disasters) and experience of horror and threat during the event (Trauma History Questionnaire; Green,1996). Blood pressure and heart rate were also assessed before and after completing the questionnaires. Nearly 90% reported at least one TE in their lifetime; 60% reported feeling horror or threat to life during the event. Indices of adjustment and reactivity were not related to objective counts of TEs alone, but in combination with the subjective experience. More felt threat was associated with lower social ($r = -.38$; $p<.05$) and attachment ($r = -.44$; $p<.01$) adjustment among women.High TE combined with high felt threat was associated with higher post-test systolic blood pressure ($F (1, 77) = 5.56$, $p<.05$, eta = .07). Heart rateacceleration from pre- to post-test was observed in the high TE group only among those who never received treatment related to the traumatic experience (Fisher Exact $p = .002$). We conclude the subjective experience of trauma events is relevant to (a) relational aspects of adjustment among college women and (b) sympathetic reactivity to thinking about trauma.

Life After Terror: Jewish and Arab Israeli Experiences

(Abstract #196019)

Poster # S-207 (Civil Ref, Disaster) **Exhibition Hall, 4th Floor**

Konvisser, Zieva, PhD[1]

[1]*Fielding Graduate University, Orchard Lake, Michigan, USA*

This paper describes the experiences of Israeli civilian survivors of terror acts since September 2000. The research is interpretive and empirical, having qualitative data in the form of narratives elicited via in-depth interviews and quantitative data in the form of survey results--Demographics, Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1995), Core Belief Inventory (Cann et al., 2007), and Posttraumatic Stress Disorder Symptom Scale (Foa et al., 1993). The purpose of this research study is to understand the individual differences in how trauma survivors understand what has happened to them, find meaning in their experiences, and make choices that involve significant life changes. This is a follow-up to my 2006 doctoral dissertation and presents the findings from two post-doctoral research studies conducted in 2007. The first study was with the same population of Jewish-Israelis as in the dissertation research study to probe for any longitudinal changes in participants' levels of functioning and to probe for the impact of the summer of 2006 Lebanon-Israel Crisis. The second study examines the experiences of a complementary sample of Arab-Israeli civilians–Christian, Muslim, and Druze.

The Art of Surviving: A Project for Public Education About the After-Effects of Sexual Violence

(Abstract #196289)

Poster # S-208 (Commun; Ethics) **Exhibition Hall, 4th Floor**

Mann, Rachel, MA, PhD[1]

[1]*University of Virginia, Charlottesville, Virginia, USA*

In 2006-2008, the Virginia Sexual and Domestic Action Alliance (VSDVAA) and Rachel Mann, MettaKnowledge for Peace, LLC, received funding from the Virginia Foundation for the Humanities to launch a project called "The Art of Surviving". This dynamic traveling and on-line exhibition consists of the poetry, art and personal narratives of survivors of sexual violence from all over the state of Virginia. Since its inception, it has hung in half a dozen locations and can be accessed for education and research by scholars, educators, activists, clinicians, and survivors. Among the main research questions of the project are included "What is the art of surviving" and "How is self-expression connected to recovering from trauma?" The audience will be able to view selected works from the exhibit digitally and in person and to give input into what they see as part of our ongoing qualitative research project. An overview of the research to date on the project will be presented. Visitors will also be given information for how to participate in the research of The Art of Surviving and how to obtain the exhibit for presentation in and education of their communities.

Participant Alert: Art, poetry and survivor narratives can be graphic and difficult for participants.

K

L

M

N

O

P

Q

R

S

T

U

V

W

X

Y

Z

THE INTERNATIONAL SOCIETY FOR
TRAUMATIC stress STUDIES
ISTSS

111 Deer Lake Road
Suite 100
Deerfield, IL 60015 USA

24th ISTSS Annual Meeting

Terror and its Aftermath

November 13 – 15, 2008

Pre-Meeting Institutes will be held on
Wednesday, November 12

The Palmer House Hilton • Chicago, Illinois USA

www.istss.org