TRAUMATIC stress points

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For resources on the Haiti Earthquake Relief, visit the ISTSS Web site.

## President's Column

*Ulrich Schnyder, MD*
*President*

First, I would like to extend my warmest wishes to all of you for the New Year.

What does a "Happy New Year" mean for people who are involved in working with the aftermath of trauma, as psychologists, psychotherapists, psychiatrists, social workers, researchers, journalists, healthcare managers, lawyers and others? Well, apart from personal joy, prosperity, health and well-being, most of us will probably wish for more peace and less violence worldwide as well as in our personal, local environment. However, the recent incident on Delta flight number 253 from Amsterdam to Detroit on Christmas Day reminded us that routine procedures, such as flying from one place to another, can all of a sudden confront us with a potentially traumatic experience.

We know that trauma can happen anywhere, at any time. But, trauma does not necessarily affect other people only. We can go to great lengths in our attempts to reduce personal risks, but still, we (i.e., you and I) can unexpectedly become a trauma survivor any time. There are no easy answers to the challenges associated with the fact that we live in an increasingly complex world. As a consequence of the Christmas incident, we will once again have to re-evaluate and determine how much personal freedom we are willing to sacrifice in favor of an increase in security.

During the year 2010, the Board of Directors will be very busy developing a new strategic plan for the ISTSS. Our last strategic planning process that resulted in a formal strategic plan document took place in 2001. Over the years, this document was revised several times. In 2008, the Board of Directors decided to involve an external facilitator to generate a new strategic plan.

We have started to think and reflect on the Society's priorities in light of recent developments in the trauma field as well as in society at large. Our aim is to develop a shared understanding of the environment within which ISTSS operates. For example, what are the key assumptions we make about the future and why do we think they are important? We will identify what ISTSS is doing now to address those issues and what we believe ISTSS needs to do in the future. Based on this assessment, we will create a description of what success will look like. We will have to focus our energies towards those practical opportunities that will deliver the greatest, most cost-effective value for ISTSS members and the trauma field. Finally, we will develop a strategic framework for practical action over the next 3-5 years to achieve ISTSS's mission and vision for the future. I will keep you updated on this important process throughout the year.

As you know, our 2010 Annual Meeting will take

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place in Montréal, Canada. The conference theme will be "Translation, Collaboration and Mutual Learning." I strongly believe that trauma is more than just "psychological trauma." It can best be understood using an interdisciplinary, multiprofessional, bio-psycho-social, and transcultural approach. Therefore, we should aim at intensifying and diversifying our professional collaboration by actively reaching out to related disciplines. The planning for the Montreal meeting takes place in this spirit: For the first time, ISTSS's Annual Meeting will be organized with a partner: the Veterans Affairs Canada (VAC) and its National Centre for Operational Stress Injuries (NCOSI). Thanks to Lina Carrese and others, we have built a strong working relationship with VAC which will hopefully result in more collaboration in the future. Furthermore, our core organizing group is actively supported by Alain Brunet, chair of the Traumatic Stress Section of the Canadian Psychological Association (CPA). We will also make an increased effort to reach out and seek collaboration in various ways with other professional societies in the field, such as the International Society for the Study of Trauma and Dissociation (ISSTD).

To better understand trauma, we need to study its devastating effects on individuals, communities and society and learn more about resilience as well. We need to encourage translational research that transfers advances in basic science to clinical applications, foster the clinician-researcher dialogue, and promote more inter-disciplinary, collaborative learning. Furthermore, we need to promote a greater understanding of the effects of trauma and processes of recovery in the mainstream of psychology and medicine, as well as in neuroscience, sociology, anthropology, and many other fields. At the 2010 Annual Meeting, we will welcome professionals from various disciplines to share their knowledge and expertise and to create an atmosphere of mutual respect and learning.

## ISTSS 25th Silver Anniversary Meeting Wrap Up

*Past President Patricia Resick, PhD, and President Ulrich Schnyder, MD, pose for a picture after Dr. Schnyder officially received the gavel.*

The ISTSS 25th Silver Anniversary Meeting went off without a hitch this past November in Atlanta, Georgia.

Attendees enjoyed a variety of research and clinical tracks, explored the exhibit hall and visited the bookstore; not to mention, the many networking events and the exciting unveiling of the new logo during the keynote session.

ISTSS honored several of its members with well-deserved awards. Recipients are listed on page 4 of this issue of *StressPoints* and in detail on the ISTSS Web site.

For more information about the meeting, visit the Annual Meeting archives.

We look forward to seeing you in Montréal!

*In celebration of the 25th Anniversary, ISTSS members sported ribbons indicating how many years they have been a part of the society.*

## Trauma and World Literature: DeLillo's *Falling Man*

Don DeLillo's novel *Falling man* concerns Manhattan families who have been profoundly affected by the attacks of 9.11.01. The passages below illustrate an effect on the behavior of three children, two siblings and a friend. The children have been sneaking away to look out of their high rise window with binoculars for a purpose which their mothers do not yet understand. The mothers are trying to figure it out in this conversation (pp. 36-37):

*"You mean what they are looking at, behind closed doors?"*

*"Can't be much, can it? Maybe hawks. You know about the red-tails?"*

*"No, It's definitely something to do with Bill Lawton. I am sure of this, absolutely, because the binoculars are part of the whole hush-hush syndrome these kids are engulfed in."*

*"Bill Lawton."*

*"The man. The name I mentioned."*

*"I don't think so." Lianne said.*

*"This is their secret. I know the name but that is all. And I thought maybe Justin. Because my kids totally blank out when I bring up the subject."*

Later, on p. 72, the secret is revealed. Lianne is talking to her husband about the children and their strange behavior:

*"The name originates with Robert. This much I know. The rest I mostly surmise. Robert thought, from television or school or somewhere, that he was hearing a certain name. Maybe he heard the name once, or misheard it, then imposing this version on future occasions. In other words he never adjusted his original sense of what he was hearing."*

*"What was he hearing?"*

*"He was hearing Bill Lawton. They were saying bin Laden."*

***Reference***

DeLillo, D. (2007) *Falling man*. New York: Scribners.

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

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

## ISTSS Call for Presentations – Be a Part of the Program

ISTSS will begin accepting abstract submissions **February 1 until March 16, 2010, 5:00 p.m., CST** (no exceptions)

This year's meeting theme is "Translation, Collaboration and Mutual Learning."Download the Call for Presentations (also available in French) and begin preparing your submission to be a part of the program! Or, visit the ISTSS Web site for more information.

## NEW! ISTSS Continuing Education Programs Earn CEs From Your Home or Office

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

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Making the right choice and choosing education sessions from ISTSS ensures you the most relevant and sensitive training from the best minds in the field, at a price that won't break your budget.

Questions? Contact: emoy@istss.org.

## Congratulations to the 2009 Award Recipients

The following recipients were presented with their individual awards during the 25th Annual Meeting in Atlanta, Georgia in November:

**Lifetime Achievement Award:** Roger K. Pitman, MD

**Robert S. Laufer Award for Outstanding Scientific Achievement:** Paula P. Schnurr, PhD

**Frank Ochberg Award for Media and Trauma Study:** Elana Newman, PhD

**Chaim and Bela Danieli Young Professional Award:** Matthew T. Tull, PhD

**Public Advocacy Award:** Matthew J. Friedman MD, PhD

**Sarah Haley Memorial Award for Clinical Excellence:** Linda A. Piwowarczyk, MD, MPH

Look for articles featuring award winners in future issues of *StressPoints*

*At the Annual Meeting in Atlanta, Keynote Speaker, Darrel Regier, MD, MPH, spoke to a standing- room-only crowd about the implications for the* DSM-V *of redesigning PTSD with empirical data.*

# Implementing and Managing a Quick-Response Research Project:

## Advice from researchers responding to the tragedies at Virginia Tech and North Illinois University

**Holly Orcutt, PhD**
Northern Illinois University

**Heather Littleton, PhD**
East Carolina University

The goal of this article is to provide practical advice and suggestions for researchers, particularly "embedded" researchers (part of the affected community), who find themselves considering conducting a quick response study following a mass trauma. The co-authors were both embedded at universities recently experiencing mass shootings. On April 16, 2007, a lone gunman at Virginia Tech (VT) killed 32 people (and himself) and wounded 25. Less than one year later on January 14, 2008, a lone gunman at Northern Illinois University (NIU), killed 5 (and himself) and wounded 18 individuals. At the time of the VT shooting, Heather Littleton, a VT graduate, was an assistant professor at Sam Houston State University, and at the time of the NIU shooting, Holly Orcutt was an associate professor at NIU. Coincidentally, we were both involved (separately) in longitudinal research on sexual victimization at these universities and thus had potentially relevant pre-shooting data. We hope that our experiences will serve as a useful guide for future researchers.

***Initial steps and resources***

If you are in a community affected by a disaster, you most likely will want to try to bring something positive and meaningful to the tragedy. You may feel strongly compelled to implement a quick response study as a way to respond. However, it is also important to consider a number of issues before moving forward. Some things to consider include: Do you have time to complete this project? Do you have sufficient research assistance or can you get a teaching release/release from clinical duties or other assistance from your department? What other projects might you have to sacrifice? Will this study fit with your program of research?

If you do decide to move forward, asking for assistance is a key first step in launching your study. For example, you may want to put out a call for assistance on professional listserves, such as Division 56 of the American Psychological Association. You also will likely want to utilize the resources of the Disaster Research Education and Mentoring Center (http://www.disasterresearch.org/). This Web site is a treasure trove of information and includes training modules, samples of successful grant proposals and instruments. Finally, you may want to contact researchers directly to ask for advice, reprints and measures, particularly as you may find yourself having to quickly familiarize yourself with a new research area.

To maximize your likelihood for success, you will want to quickly assemble a research team. It can be very helpful for your team to have some members outside of the affected community, because embedded team members are also dealing with the disaster. Within the affected community, evaluate the potential for collaboration with other researchers and assess whether you are duplicating efforts or competing for the same funds. It is also important to consider how to prevent participant fatigue from multiple studies.

You will also want to put together a preliminary budget as soon as possible – have a "lean" budget that focuses on participant recruitment and retention. Write a brief concept paper as well to share with potential funding sources. As you develop your concept paper, several pitfalls to avoid include assuming that: (1) because you have data from participants prior to the disaster, that it is automatically of value, (2) because you are focusing on a disaster, that other aspects of the study will not be looked at as critically (e.g., novelty, feasibility), and (3) participants will want to be involved in the study because it concerns the disaster.

In terms of funding options, keep in mind that your office of sponsored projects may not be experienced in obtaining emergency funding. In fact, most traditional funding sources are not rapid enough for a quick response study. One exception is the Grants for Rapid Response Research (RAPID) through the

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National Science Foundation. The Disaster Research Education Mentoring Web site includes examples of successful RAPID grants. The RAPID requires a very brief proposal. It is reviewed internally and funds are available quickly (within weeks). Heather's quick response study was funded by the previous incarnation of RAPID (known as SGER). The National Institutes of Health (NIH) also has a RAPID mechanism. However, NIH requires a full proposal that is sent for external review, and thus obtaining funding will likely take several months. Thus, you may need to consider funding from non-traditional sources. For example, Holly obtained funding for an immediate post-shooting survey from a grant from a private foundation targeting gun control as well as from funds advanced by NIU. Later, Holly obtained additional funding from an NIH RAPID grant.

***IRB Issues***

You may face a number of IRB issues as well. For example, it is likely your IRB has received a number of applications involving collection of time-sensitive data. At the same time, the IRB's functioning may be disrupted by the disaster. The IRB may also have to comply with guidelines imposed by outside groups. For example, a special panel had to approve all VT shooting-related research. Finally, if the trauma involves a crime, the IRB may have to comply with legal requirements, such as federal laws regarding evidence retention. Thus, it is imperative that you communicate frequently with the IRB and seek consultation with other researchers regarding how to handle potential IRB concerns.

***Project Process***

If you are able to successfully implement a quick response study, it is also imperative that you remain flexible and willing to make changes. You may want to consider collecting qualitative data to gain a more comprehensive perspective on participants' experiences and to suggest possible directions for gathering additional quantitative data. It is also important to be prepared for unexpected problems and to not be too harsh with yourself for not anticipating these problems. After all, you put together a successfully funded project in a very short time frame while at the same time managing the effects the disaster had on you.

It is also important to be mindful of your own emotional well-being. It is likely that you will have mixed emotions if your project gets funded, as this opportunity came as a result of tragedy. It is also likely that working on the project will bring up your own thoughts and feelings about the disaster. Thus, it is imperative that you practice good self-care, including monitoring your own reactions, ensuring that you take time to process your own thoughts and emotions, and, if necessary, shifting responsibility for portions of the project to others.

To conclude, for both of us, implementing a quick response study in the wake of disaster has been both a highly challenging and rewarding endeavor. We hope that if you ever find yourself in the difficult position of conducting research following a disaster in your community that you find our advice to be helpful[1].

[1] Portions of this paper were presented at the 5th Annual Conference on Innovations in Trauma Research Methods, 2008, Chicago, IL


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# Book Corner

**Gilbert Reyes, PhD**
Fielding Graduate University

**Review of:** Kilmer, R. P., Gil-Rivas, V., Tedeschi, R. G. & Calhoun, L. G. (Eds.). (2010). Helping families and communities recover from disaster: Lessons learned from Hurricane Katrina and its aftermath. Washington, D.C.: American Psychological Association.

In 2005, the United States experienced the most destructive series of hurricanes on record, including Hurricane Katrina, the most destructive storm in U.S. history, which in turn led to the largest ever evacuation and long-term population displacement. The potentially traumatic experience connected to this event, and the broader social and psychological consequences for hundreds of thousands of children and adults, prompted an unparalleled response from social service agencies and mental health professionals.

A vast network of industrious and inventive programs, partnerships, and research studies soon emerged. The editors of a new book titled, *Helping families and communities recover from disaster: Lessons learned from Hurricane Katrina and its aftermath*, have gathered a highly instructive collection of chapters describing many of the problems, solutions, and results that defined the efforts to assist the affected families and communities.

This book begins with an introduction to ecological systems theory to provide a conceptual framework illuminating the developmental challenges faced by disaster survivors, and to help identify the most effective strategies for providing psychosocially effective assistance.

Cultural variation is among the most essential of the contextual factors in human ecology, and this book never loses sight of that. The early chapters describe the ecology prior to the disaster, and the challenges of providing assistance that sensitive and responsive to culturally differences. Recommendations are made for how to correctly identify human needs, honor human rights, and support locally sustainable efforts, decisions, and priorities. Schools as identified as providing the most accessible and acceptable context for delivering services and interventions, challenges of coordinating efforts among multiple agencies are described, along with the need for flexible strategies, accountability, and assisting adults so that they can better help their children are emphasized.

The middle of the book is dedicated to a set of research projects, including an empirical study of how children's adjustment to the disaster was influenced by relationships with caregivers; an examination of how children's externalizing behaviors might be related to aspects of stress exposure and parenting styles; a qualitative summary of themes found in survivor interviews; a mixed qualitative and quantitative study of variation in how grade school teachers incorporated disaster-relevant lessons into the post-disaster curriculum and a qualitative study examining the suitability and accessibility of services provided for hurricane-affected children and families. Although these studies provide valuable information, they also reveal weaknesses found in disaster mental health research, among which are reliant on methods of sampling and measurement that severely limit the reliability and generalizability of the findings.

**The editors…have gathered a highly instructive collection of chapters describing many of the problems, solutions and results that defined the efforts to assist the affected families and communities.**

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Thus, at times the most compelling and convincing parts of these chapters are found near the end when the authors summarize their conclusions and recommendations for future action, even if they sometimes seemed to be informed more by predispositions or experiences rather than being clearly linked to the data and the findings being reported.

The latter part of this book relies on case examples, literature reviews, and professional background to identify and address key matters of policy and practice across a variety of important contexts and institutions, such as schools, community service agencies, governmental agencies with disaster relief responsibilities, faith-based organizations and first-responders.

A chapter describing approaches to strengthening resilience at the community level is particularly instructive and thought provoking. Another chapter describes the principles and practices of early intervention techniques, like psychological first aid, with an emphasis on consideration ensuring that these interventions are grounded in empirical evidence and with due regard to confidentiality, informed consent and other ethical issues. The lead editors conclude by summarizing the most critical issues, themes, conclusions, and recommendations for further action that were articulated or implied across the entire book.

**…there will be no good excuses for not having learned from the innovations, investigations and dedicated efforts of those who aided these children and families…**

The editors and contributing authors are to be commended for sharing their experiences of working with hurricane survivors and helping to advance the field of disaster psychology. While there are variations in the quality and utility of the chapters for a wide variety of purposes, it is important to make the stories presented in this volume available to those who may someday need to respond to disasters of comparable magnitude.

The lessons contained among the pages of this book deserve the attention and respect of those who will design and implement mental health and community resilience projects in response to future disasters, and there will be no good excuses for having not learned from the innovations, investigations, and dedicated efforts of those who aided these children and families in the aftermath of Hurricane Katrina.

## Visit the ISTSS Amazon Store

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

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

**Titles featured in this issue are available at the ISTSS Amazon Store, including:**
*Helping families and communities recover from disaster: Lessons learned from Hurricane Katrina and its aftermath* and *Falling man*.

Visit the Amazon Store for other resources on natural disasters and trauma.

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

## Media Matters

# Talking About Research: A Case for Qualitative Evidence

**Patrice Keats, PhD**
Simon Fraser University

From panel discussions to SIG meetings, this year's Annual Meeting offered many opportunities for discussions about dissemination and the relevance of trauma research to members as well as participants in trauma research programs (e.g., journalists, editors, families).

To clarify the role that qualitative research can play in making trauma research relevant and its means of disseminating important knowledge about trauma, this article reviews some of the roadblocks that have impeded the full consideration of qualitative research as a legitimate form of inquiry. When qualitative research is marginalized or neglected, we lose important opportunities to disseminate results and risk alienating those who are in a position to benefit from trauma research, such as trauma practitioners and the people they help.

Particularly interesting to me is the common misunderstanding of the value and relevance of qualitative research; for example, when discussing qualitative evidence during the Annual Meeting, one person said, "when I think of qualitative research, I think, 'oh, stories'." Media SIG members have expressed concern about the lack of innovation when disseminating research results to journalists. Since greater understanding and increased integratability of research in the journalism community can better assist those reporting and photographing trauma firsthand, as well as their supporters in the newsroom and at home, I argue that qualitative evidence must be recognized as an indispensable, relevant, and valued aspect of knowledge acquisition in the exploration of trauma, and that qualitative methods promise innovative ways of disseminating results so that they are relevant and practically applicable.

Rennie, Watson and Monteiro (2000) presented a study noting that the field of psychology was especially dedicated in adopting positivism and was resistant to departures from accustomed research practices and alternative sources of evidence (i.e., qualitative research methods). Consequently, faculty was unlikely to support or promote qualitative research, and they saw limited funding for studies using qualitative methodologies. The authors warn that "once knowledge is defined by method, then institutions of power...are organized to materialize the definition. From then on, claims to knowledge based on alternative methods are either ignored or dismissed" (para. 26). This leads to questioning what is endorsed as evidence (especially *best* evidence), who controls the definition of evidence, and which kinds are acceptable to whom.

**When qualitative research is marginalized or neglected, we lose important opportunities to disseminate results…**

Among researchers, randomized control trials (RCT) are often referred to as the "gold standard" for making comparisons between different kinds of treatment (e.g.,Foa, Keane, & Friedman, 2000). When Cochrane (1972/1999) published his criteria evaluating treatment efficacy, it soon became the standard for evaluating *all* research (Morse, 2006a). Although RCTs are needed to determine the efficacy of treatment, some questions (e.g., investigations immediately after disaster, case studies of rare events, microanalysis of video recordings of therapeutic processes) do not require randomized trials or examinations of associations between variables.

Worrall (2002) states that, in answering specific questions, selecting the best external evidence from a range of choices is most appropriate. Useful and valid information can be gleaned through observations and descriptions; as Morse states, even "logic and common sense can

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produce powerful forms of evidence" (p. 403). If there is no randomized trial for a person's predicament, the next best external evidence needs to be accessed; a self-evident intervention, for example, can be judged effective if its omission would have done more harm than good (Sackett, Rosenberg, Muir Gray, Haynes, & Richardson, 1996). Additionally, we need to attend qualitatively to the large contextual variation within people's presentation of issues, especially in relation to their unique contexts, cultures, and expectations (Morse).

**…the Dart Web site shows that members of the journalism community are interested in reading and engaging with information with qualitative elements…**

Humanistic disciplines (e.g., journalism studies, counseling) study the interpersonal relations involved in *care* rather than the therapeutic efficacy of specific *cures* (Morse, 2006b). Where quantitative researchers seek to "transform perceptions and emotions into direct data by asking the participant to score the event numerically" ( p.419), qualitative researchers attempt to understand the complexity of participants' experiences, perceptions, and emotional responses by gather data that is *direct* (descriptions of actual concrete phenomenon), *semi-direc*t (direct reporting on non-concrete, subjective phenomenon), or *indirect* (inferential or implicit). Morse contends that indirect data contributes especially to "concept and theory development," and that this type of data "make[s] good qualitative research stimulating, surprising, exciting and innovative" (p. 418).

Thus, the research agendas of qualitative and quantitative inquiry are incommensurable in terms of process and inference.

In this evidence-quality-standards discourse, Denzin (2009) states that it is counterintuitive to assert that "qualitative research does not count as research unless it is embedded in a randomized controlled trial" (p. 140).

When Greenberg (2009) stated that "words are written down...anecdotes...but they are not *hard* science," I thought about the way that trauma information and research is presented to journalists on the Dart Center for Journalism and Trauma Web site (dartcenter.org). Specifically, along with video clips and experiential learning opportunities, one finds short articles (anecdotes) that emphasize the human element as central. As a site for research dissemination, the Dart Web site shows that members of the journalism community are interested in reading and engaging with information with qualitative elements (e.g., language, meaning, experience). On this basis, I suggest further engagement of participants in innovative and useful research dissemination strategies. I also affirm that there is much to learn from qualitative research, and that embracing qualitative research as an equal partner to quantitative methods in the creation of knowledge is critical to disseminating research and making research relevant to diverse stakeholders.

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# Kevin's Story: A Review of the Master Clinician Series

**Joshua Friedlander, PsyD**
Dr CIV USA MEDCOM WRAMC

I recently had the opportunity to play, "Kevin," a combat veteran with posttraumatic stress disorder (PTSD) who was "treated" by five different Master Clinicians at the ISTSS Annual Meeting. Each reviewed and then demonstrated their therapeutic approaches with me over the course of ninety minutes. Since then I have had the chance to reflect on these experiences and would like to share my thoughts about them in turn. I will emphasize in particular, what I felt was distinctive and helpful about each approach and also try to describe what they felt like and what was challenging about each. For those who did not have the chance to see the demonstrations, here is a brief synopsis of my background and current symptoms. It should be noted that my history and symptoms are a composite of several veterans with PTSD related to Operation Iraqi Freedom and Operation Enduring Freedom.

## Therapeutic Approach: Prolonged Exposure Therapy (PE)

**Master Clinician: David Riggs, PhD**
In this demonstration, Dr. Riggs illustrated the application of PE. What I found particularly helpful was Dr. Riggs' focus on treating my avoidance of driving using *in vivo* exposure. He helped me figure out how to analyze this problem and make a plan for how to expose myself to those situations in a gradual manner, beginning with exposing myself to situations of medium stress. He explained that if I practice consistently on those similar situations and stayed in the situation long enough, about 30 minutes, my anxiety would reduce over time with enough repetitions. This approach to reducing my anxiety when driving made good sense to me, and gave me a very specific plan for how to do it.

## Therapeutic Approach: Acceptance and Commitment Therapy (ACT)

**Master Clinician: Sonja Batten, PhD**
In this demonstration, Dr. Batten illustrated the application ACT to my problems. What I found particularly helpful was Dr. Batten's focus on helping me figure out a different approach to all of my symptoms. This felt different in comparison to the other approaches.
The other approaches seemed to focus on "doing something" to my symptoms whether it was my thoughts, feelings, physiological symptoms, or behavior.

In contrast, Dr. Batten helped me focus not on "doing something" to my symptoms as the other approaches advocated, or on fighting or trying to shut them down and control them as I have been trying, but on finding a way to "make room" for them, so to speak, as part of myself.

For example, we used the metaphor of my intrusive thoughts as ping-pong balls, which were consistently coming at me and I was trying to swat away, but which were ultimately harmless. I felt different when I started not pushing my thoughts away, as if a emotional burden was somewhat lifted. It allowed me to give up trying to control my thoughts.

## Therapeutic Approach: Cognitive Processing Therapy

**Master Clinician: Kate Chard, PhD**
In this demonstration, Dr. Chard illustrated the application of CPT. What I found particularly helpful was Dr. Chard's focus on helping me understand the connections between my thoughts, feelings, and behavior. This proved very helpful as I had been plagued with guilt about having given up on myself and of missing the IED.

She helped me analyze my thoughts with certain types of questions, bringing to bear all the details and context of what was going on at the time of my traumatic event. Going through these steps, I was able to discover on my own that I am not to blame for not being able to get to my buddies or for missing the IED.

She then helped me come to a more accurate and realistic way of thinking about what happened.

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This completely changed my feelings of what happened and I felt less guilty. I have had friends and doctors who tried to say the same thing to me before, but with them it felt like they were trying to change my mind or convince me. With Dr. Chard, it felt like we were working on this together. She then explained how I could use this same approach to help with my other symptoms.

### Therapeutic Approach: Virtual Reality Exposure Therapy (VRET)

**Master Clinician: Barbara Rothbaum, PhD**
What I found particularly helpful was Dr. Rothbaum's focus on having me tell the story of what happened in the present tense, with the aid of virtual technology. The virtual technology simulated my visual experience by looking at a computer-generated environment through eye gear, my physical experience by sitting on a vibrating platform, and my auditory experience by reproducing sounds of gunfire and explosions.

I still remember the physical sensations of vibration that were similar to driving in my humvee. This approach was challenging in that I had to tell the story several times even when it stirred up anxiety. However, going through that gave me confidence that I didn't have to spend so much energy trying not to think about it, and the anxiety also began to go down at the end. There was one time of telling my story where I closed my eyes to stay on track with my story because the video got stuck.

Though similar to PE, I found the technology helped to make the experience more vivid and involving, but also more challenging since it was more vivid. Dr. Rothbaum also helped me to think more accurately and realistically about what happened and how to begin to accept the fact that I cannot control everything.

### Therapeutic Approach: Unified Protocol

**Master Clinician: David Barlow, PhD**
In this demonstration, Dr. Barlow illustrated the application of UP. What I found particularly helpful was Dr. Barlow's focus on helping me reduce my physical anxiety. I've had significant anxiety whenever I drive or am in crowds. He helped me to understand how my physical anxiety leads to my isolation.

To help reduce my anxiety, he had me simulate it in session by invoking hyperventilation and by spinning around in my chair. These activities produced the same kind of physical sensations of anxiety that I get when driving, in crowds, and other trauma-relevant situations. By experiencing these in session, I learned how to cope with them and also how to cope with them whenever they arise outside of therapy sessions.

**Discussion**
After experiencing these different therapies I reflected on their similarities and differences. In general, I found all of the approaches very helpful, yet it was interesting to me that I found them helpful in different ways. I found PE, CPT, VRET and UP similar in a global sense in that they helped me focus on analyzing my specific thoughts, feelings, physical reactions, and behavior, in their various ways to help reduce them. In contrast, ACT felt different in this way, because it discouraged analysis of these specific symptoms.

ACT changed my overall approach to them from analyzing or controlling them to finding a different way to relate to them, such as making room for them and accepting them. PE helped me figure out how to reduce my physical anxiety and avoidance in very specific current day situations, such as driving. VRET was similar to PE in approach, but the addition of the physical sensations had a mixed effect for me. VRET helped me re-experience my memory more vividly, but because it was more vivid, I felt more of a desire to avoid the memory.

CPT in particular helped me focus more on my thought processes, which contributed to a broad range of my symptoms, including anxiety, guilt, and anger. CPT more than the others helped me learn to analyze my thoughts, find the thoughts that were contributing to my symptoms, and figure out how to think more accurately and realistically. This helped reduce all my symptoms, and particularly my guilt. I found UP helpful because I was able to practice coping with my physical symptoms in a general sense, not just specifically tied to particular situations. That is, even though I definitely avoid certain types of

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*Kevin's Story continued from page 12*

situations due to my physical anxiety, there are, in fact several situations which trigger anxiety and avoidance. In sum, I found all were helpful in their own way and emphasized different parts of my symptoms.

This experience reminded me of the blind man's description of the elephant, with each therapy touching on a different part of the elephant, but each affecting the entire elephant. It made me wonder, since they were all helpful in different ways, can mental health practitioners take the best from them, depending on a particular patient's symptomatology and preference for therapy approach?

Different overlapping parts of an elephant? Like Venn Diagrams? I'm not sold on this, there may be a way to illustrate which symptoms I felt the therapies targeted, or list them in order in terms of where they put their focus, since I think PE/CPT/VRET/UP hit them all but in different degrees of emphasis, where as ACT had a different approach to the whole elephant, like ring master in a circus working with the elephant.

(Coming soon! Several Master Clinician Sessions were recorded at the 2009 Annual Meeting and will be available for 1.5 hours of CE credit each.)

## REMINDER - REGISTER NOW!

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

This one-day symposium's plenary sessions and workshops will provide cutting-edge information for psychologists, psychotherapists, psychiatrists, social workers, researchers, journalists, healthcare managers, lawyers and others involved in working with the aftermath of trauma.

Most of the presentations are in English, while some are in German, but without simultaneous translation.

Visit the ISTSS Web site for more information. Here is the brochure of the program providing you with all the details! You can easily Register NOW Online. Members of ISTSS and members of ISTSS affiliate societies are eligible for reduced registration fees!

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## Upcoming Events

**February 24-26, 2010**
National Summit on Interpersonal Violence and Abuse Across the Lifespan: Forging a Shared Agenda
Sheraton Dallas Hotel
Dallas, Texas USA

**April 7-10, 2010**
Association for Death Education and Counseling (ADEC)
32nd Annual Conference
Hyatt Regency Crown Center
Kansas City, Missouri, USA
www.adec.org/conf/index.cfm

**April 8-10, 2010**
European Society for Trauma and Dissociation International Conference
Queens University Belfast, Northern Ireland
http://www.estd.2010.org

**April 17, 2010**
ISTSS Psychotraumatology Meeting
Zürich World Trade Center
Zürich, Switzerland

**June 2-5, 2010**
6th World Congress of Behavioral and Cognitive Therapies (WCBCT)
Association for Behavioral and Cognitive Therapies
Boston, Massachusetts, USA
Boston University and the (ABCT)

**November 4-6, 2010**
ISTSS 25th Annual Meeting
with Pre-Meeting Institutes Nov. 3
Le Centre Sheraton Montreal Hotel
Montreal, Quebec, Canada
www.istss.org

**November 3-5, 2011**
ISTSS 26th Annual Meeting
with Pre-Meeting Institutes Nov. 2
Baltimore Marriott Waterfront
Baltimore, Maryland, USA
www.istss.org

**November 1-3, 2012**
ISTSS 28th Annual Meeting
with Pre-Meeting Institutes Oct. 31
JW Marriott Los Angeles at L.A. LIVE
Los Angeles, California, USA