TRAUMATIC stress points

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President's Column

Marylène Cloitre, PhD
President

As the 2011 year ends, I wish to relay to you activities which have come about due to and in accord with the six strategic goals to which ISTSS has made a long-term commitment.

Among the most important of goals is to have ISTSS become and feel like a "professional home" to its members. Accordingly, as a first step, this year the board has worked hard to conduct a series of surveys asking members what they want, like and dislike. Surveys such as these will be sent out each year and will contribute critical information to decision-making about future directions regarding content at the conference, on the website and in the journal, what technical innovations we should support, and how to grow SIGs, committees and member initiatives. Please complete these surveys when you get them and let your opinions and ideas be known.

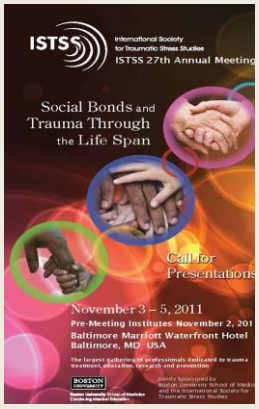
Complementary to these efforts, three important task forces were formed this year. The **Organizational Excellence Task Force** will be providing recommendations in approximately six months regarding how best to organize, energize and support committees to create stability, support innovation and increase the value and benefits of the society to members. The **Data Infrastructure Task Force** has completed its report and has recommended several advances, which include an upgrade of our data platform and data analytic capacities, the development of an easy-to-use system for routine survey implementation, and a system for linking disparate member information data sets so that we can get a "wholistic" view of member preferences and activities. We thank the members of this task force for their efforts and in particular Dawne Vogt who very ably led this group.

IN THIS ISSUE:

The **Global Initiative Task** Force continues the very serious work of considering a major reorganization of ISTSS so that it can function more truly as an international society and meet its mission to be a global society. All of the options that are now being considered involve creating strong partnerships with international members, affiliates and societies. **A very important Town Hall Meeting will be held during the upcoming Annual Meeting on Thursday, November 3rd at 6:15-7:00 p.m. in Grand I & II. All members are invited to attend to voice their opinions.**

This is my last column as ISTSS President. I am taking this opportunity to thank the membership who placed their confidence in me as president. We have accomplished quite a lot this year particularly in regards to creating and acting on a new vision for our society. It is an incremental process but the steps are discernable and the footing is solid. I give my best wishes and support to Eve Carlson, who will be president in the 2012 year. Best wishes!

Join ISTSS in Baltimore for the 27th Annual Meeting!
November 3-5, 2011
Baltimore, Maryland, USA



The 27th Annual Meeting of the International Society for Traumatic Stress Studies (ISTSS) is just around the corner. The meeting will be held at the Baltimore Marriott Waterfront Hotel from November 3-5, 2011, with Pre-Meeting Institutes on November 2. **Advanced registration has closed, but you can still register on site starting November 2.**

The ISTSS Annual Meeting is the year's largest gathering of professionals dedicated to trauma treatment, education, research and prevention.

This year's theme is "Social Bonds and Trauma Through the Life Span." The meeting includes more than 100 presentations, symposia, workshops, case studies, panels and posters over three days.

2011 Annual Meeting Highlights:

Four Keynote Sessions

Eight Featured Presentations

Three Master Clinician Sessions

12 Pre-Meeting Institutes

Questions? Contact ISTSS.

The ISTSS 27th Annual Meeting is supported in part by education grants from the following:

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Sheppard Pratt Health System

The Trauma Disorders Program at Sheppard Pratt, part of the nationally and internationally renowned Sheppard Pratt Health System, provides inpatient treatment for all stages of psychological trauma recovery. Integrating an intensive multi-disciplinary approach through individual therapy, milieu, and process-oriented, experiential and psycho-educational group therapies, our expertly trained treatment team provides a structured, supportive environment to facilitate stabilization and step-down to other levels of care, both in our continuum and in home communities.

Psychological Impact of Spring Nuclear Plants Disasters

Elena Cherepanov, PhD, LMHC
School of Psychology and Counseling, Cambridge College

Three Mile Island, Pennsylvania (16 March 1979)
Chernobyl, Ukraine (26 April 1986)
Fukushima, Japan (11 March 2011)

Radio-nuclear disasters (RND) can evoke feelings of horror, helplessness, hopelessness and a sense of loss of control over one's own life. The uniqueness of any radioactive incident is that its impact is oriented to the future and is associated with health concerns related to the delayed consequences of the radiation exposure. The analysis of past RND, such as Hiroshima and the "Spring Nuclear Plants Disasters", allows us to better understand their immediate and long-term psychological impact. Preparedness and community education will assure adequate and timely response and support.

From 1987 to 1993, I assisted survivors of the Chernobyl disaster. I was responsible for organizing the direct care to the affected communities as well as trainings for teachers, psychologists and medical professionals. During that time, I noticed remarkable similarities between survivors' reactions and themes following the Chernobyl disaster to those observed in other RND incidents. Here I describe some of the similarities I noted:

- The RND have *multi-system and multi-level* impact. The recognition of the complex medical, social, economic and political consequences of RND is important for better understanding of psychological responses.
- *The impact of RND extends to the future.* The survivors' worries about their own health are in addition to fears about the health of their progenies: the presence of radioactive agents will likely continue affecting the ecology and health for future generations (EPA, March 2011).
- The development of *conspiracy theories, mythology, and magic thinking* reflect the inherent need to make sense of the senseless catastrophe by giving the experience a special meaning, and creating a sense of predictability. For example, in Chernobyl, there is a persistent idea that the explosion (Chernobyl is translated from Belarusian as Wormwood) has been predicted in the Book of Revelation as a sign of the end of the world (The King James Bible, Revelation 8:10, 11, p. 306).
- The common initial delay or minimization in disclosing the incident by the authorities often leads to *informational wars* and fosters *distrust of the authorities and the public information they provide*. Rumors and misinformation quickly fill the information gap and can be very damaging and undermining for the recovery efforts.
- Radiation can spread and penetrate through air or walls leaving survivors with no *perceived place of safety*. If they flee, they often face stigmatization and discrimination. In Japan, Hibakusha (from the Japanese word "explosion-affected people") were often refused employment. It was difficult for Hibakusha women or men to get married, as many feared they would give birth to deformed children (Terkel, 1984). The Chernobyl survivors, who also reported employment discrimination, were nicknamed "Fireflies," due to the belief that they glowed in the dark. On many occasions I was told about the parents not allowing their children to be friends or even to share the school desk with Chernobyl children because of the "radiation contagiousness"; and that the marriages with Chernobyl survivors are strongly discouraged out of fear for birth defects in children.
- *A sense of foreshortening future* is linked to higher rates of depression, anxiety and hopelessness. Svetlana Alexievich (2005), a Belarusian investigative journalist, reported that "a liquidator" (firefighters who were called to extinguish the fires) stated, "In Afghanistan I knew that when I return- I'll live. In Chernobyl it's the opposite- when I return- I'll die… (p. 41)". In the Chernobyl area, where many survivors believed in the imminent death within several years, I met teenagers having a hard time understanding why they have to go to school, or to clean their room: "If I won't live past 16 years old, why bother?"

RND continued on page 4

RND continued from page 3

- *Lingering medical concerns* are tied to an astounding *lack of consistent data* about the long-term health effects of small doses of radiation (Health Effects Radiation Protection, 2011). The prevalence of psychosomatic or medical conditions exacerbated by extreme and prolonged stress still remains unclear. Hyper-vigilance to physical health and interpretation of any physical discomfort as radiation sickness keeps reviving the paralyzing feeling of impending doom.
- The survivors identify *the main sources of their resilience* as culture, spirituality, humor, references to the past survival experiences (Belarus and Ukraine badly suffered during WWII), and quick return to the life routines. Chernobyl survivors have crafted jokes where they make fun of radiation-caused mutations: A double-headed eagle, which is a part of Russian national emblem, did not escape this dark humor.

Understanding commonalities across RND responses is important for developing recommendations to minimize the psychological impact if a similar incident occurs in the future.

- The RND preparedness and the response plan need to be comprehensive, systemic, and multidisciplinary, and executed and managed in a coordinated and collaborative way.
- It's important that the official information provided about disaster is accurate, timely and balanced. This helps to prevent panic, and eliminate rumors and misinformation.
- It's essential to encourage survivors to get back to their life routines as quickly as possible, or to establish new routines and rituals in the places of relocation.
- In case of forced relocation, it is unclear if the relocated survivors benefit more from compact or dispersed resettlement, but in either case the communities need extensive psychological support and education.
- The health concerns should not be blankly disregarded. The primary care workers must be trained to screen the psychosomatic conditions in order to make appropriate referrals.
- The aid must be based on the multi-system needs assessment. In Chernobyl there were instances when orphanages received oranges as humanitarian aid, while the children were lacking basic clean foods and formula leading to the public outrage, which left the impression of a public relations stunt.
- The aid has to be planned to attain both the immediate and long-term needs. There is no expectation that the trauma counselors will be able to stay in the area long enough. Consequently, the sustainability and reliance on local infrastructure, trainings and supports of local cadres bears great importance. This includes public, professional education, and training for community members. The community education also is needed in places of relocation to make the communities ready for the resettlement of evacuees from the contaminated areas.

Author's Note*: I feel privileged to have worked with my Belarusian colleagues to assist the survivors of Chernobyl disaster.*

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War at Home – Consequences of War Trauma on Family Life

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In recent years, growing evidence has shown the devastating effects of war on the mental health of the affected people, military personnel (Dohrenwend et al., 2006; Smith et al., 2008) as well as the civilian population (Neuner et al., 2004). One of the most vulnerable groups in this context are children who are affected by high rates of post-traumatic stress disorder (PTSD) and comorbid affective and somatic problems (Catani, Jacob, Schauer, Kohila, & Neuner, 2008). Beyond the immediate effects of war experiences, the development of children in war zones is threatened by a wide range of secondary factors, such as homelessness, malnutrition, loss of a parent, or domestic violence (Pynoos, Steinberg, & Piacentini, 1999). It is therefore not only the direct, personal consequences of the experience of war that are relevant for a child, but also the multifaceted effects of war on family life, on parenting behavior, and on the social and economic conditions that affect the family.

A cycle of violence in the context of war

The original formulation of the "cycle of violence" hypothesis (Widom, 1989) predicts that the experience of maltreatment as a child increases the probability of the person using violence as an adult, thereby perpetuating a continuous cycle of violence and abuse. Psychological disorders resulting from the experience of violence, particularly PTSD, seem to act as a mediator in this relationship. Interesting results were found in a meta-analysis of 39 studies on the relationship between anger/hostility and PTSD diagnosis (Orth & Wieland, 2006): There was a significantly stronger association between PTSD and anger/hostility in military samples involving war trauma, than in samples involving other traumatic experiences.

Thus, the question is whether we can assume a "cycle of violence" also for the context of war by which high levels of war violence lead to higher levels of violence within the family and community. Even so research on this topic is still scarce, there is growing evidence to support this assumption. One line of evidence comes from studies investigating intimate partner violence among couples where one or both partners are affected by the war or are living in war-torn regions. Studies with war veterans found high rates of violence against partners (Heyman & Neidig, 1999) and, again, empirical support for the mediating role of PTSD (Riggs, Byrne, Weathers, & Litz, 1998). Further evidence comes from a large survey in the occupied Palestinian territory showing that exposure to political violence in men is associated with increased odds of physical as well as sexual intimate partner violence perpetrated against their wives (Clark et al., 2010).

Unfortunately, research has neglected the study of child maltreatment in military families, so far, and the question of whether war violence experienced by parents might lead to harsher parenting styles and aggression towards their children cannot be answered clearly at this point. Based on the evidence from a handful of studies on this topic the assumption of such a relationship seems reasonable. For instance, Rentz and colleagues found that violence against children increased considerably during times when a family member went off or returned from combat deployment (Rentz et al., 2007). In addition, a longitudinal study with National Guard soldiers who had been deployed in Iraq and their families showed that PTSD symptoms in the direct aftermath of deployment predicted the severity of parenting challenges one year later (Gewirtz, Polusny, DeGarmo, Khaylis, & Erbes, 2010).

"Unfortunately, research has neglected the study of child maltreatment in military familes, so far…"

War at Home continued on page 6

War at Home continued from page 5

War-torn families

The dramatic consequences of war and other forms of organized violence become particularly complex, when the entire family is affected or lives in a conflict zone. How does a child grow up, if not only is his father traumatized, but also his mother, his siblings, and, above all, he himself, are exposed to repeated traumas of wartime violence? Initial evidence comes from a study with more than 1,000 Palestinian adolescents indicating an increased rate of physical violence within the family (Haj-Yahia & Abdo-Kaloti, 2003). The strongest predictor for the amount of violence experienced by the adolescents at home was the number of political stressors to which the family was exposed to. Surveys with school-children in Afghanistan and Sri Lanka (Catani, Jacob, Schauer, Kohila, & Neuner, 2008; Catani et al., 2009) indicated that physical violence within the family was much higher than in politically stable Western countries. In both samples, the amount of war experiences reported by the children resulted as a key predictor of family violence. These findings were confirmed by a longitudinal survey in two Kabul schools highlighting the importance of family violence over war-related as well as socio-economic stressors in predicting changes in mental health problems in Afghan children (Panter-Brick, Goodman, Tol, & Eggerman, 2011). Here, the authors concluded that "domestic violence is often a response to structural and collective violence" (Panter-Brick et al., 2011, p. 360). Taking these findings together, it seems that the specific interplay of stressors and traumas on various levels (individual, family, and community) appears to make families, and especially children, particularly vulnerable to the development of psychological disorders such as PTSD (Catani et al., 2010).

The exact mechanisms behind the link between the experience of war and family violence remain to be elucidated. Some preliminary findings indicate that the relationship might be mediated by the emotional and behavioral changes that occur in reaction to traumatic exposure in both parents and children, for instance externalizing problems in children and youth (Punamaki, Qouta, & El-Sarraj, 2001), and PTSD and substance abuse in parents (Taft, Street, Marshall, Dowdall, & Riggs, 2007). It can be assumed that traumatization of parents and children might lead to a family dynamic in which posttraumatic emotional and behavioral disturbances of both parents and children contribute to a reciprocal aggravation of dysfunctional interaction patterns. However, no definite conclusions can be drawn at this point since research addressing the complex relationships between war experiences and associated changes on the family and societal level is still in its first stages, in particular when it comes to longitudinal studies with war affected populations. Such studies are crucial for a better understanding of the effects of war violence on family life which in turn is essential for the development of appropriate intervention programs to prevent violence and to treat the consequences of violence in (post-) war communities.

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War at Home continued on page 7

War at Home continued from page 6

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Trauma and World Literature: Kathryn Stockett's *The Help*

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PsyCare, Inc. &
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The Help (Stockett, 2009), a novel set amidst the racial tensions of Mississippi in the early 1960s, showcases the progressive vision of Eugenia "Skeeter" Phelan. A young Caucasian journalist, Skeeter rises to a challenge issued by a publisher to write about what disturbs her, especially if it is a subject that bothers no one else. In the novel, Skeeter ultimately persuades a group of African American maids working in Jackson, Miss., to share their experiences about the realities of their work life. The collection is eventually published as an anonymous volume, creating a profound ripple-effect in both the black and white communities of Jackson. Because of the racial climate, convincing a group of 12 African American maids to share their stories was no easy task. Initially, one of the most resistant participants was Minny, a survivor of domestic abuse in her own home who had also been fired from countless households in the Jackson area because of her intolerance of the extreme demands of subservience.

A trauma-sensitive reader can easily detect that Minny's anger and reactivity serve as survival mechanisms. As with many survivors of traumatic experiences and racial oppression, telling her story becomes a very powerful modality for healing within Minny. In this passage from *The Help*, we consider how the process of telling her story was initially very difficult, just like it is for many people who seek treatment for concerns related to traumatic experiences:

> *"I don't want anybody to know how much I need those Skeeter stories…that's pretty much all I got. And I'm not saying that the Miss Skeeter meetings are fun. Every time we meet, I complain. I moan. I get mad and throw a hot potato fit. But here's the thing: I like telling my stories. It feels like I'm doing something about it. When I leave, the concrete in my chest has loosened, melted down so I can breathe for a few days."*

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Contribute to *StressPoints*

Trauma and World Literature Feature

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

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

Addressing the Needs of Families Who Cope with Chronic Poverty & Trauma

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Editor's Note: *Dr. Kiser will lead a pre-meeting institute (PMI) on "Strengthening Family Coping Resources: Multi-Family Group for Families Coping with Multiple Trauma." For information about this and other PMIs, visit the ISTSS website.*

With reports of growing numbers of people living in poverty, attending to the damaging effects on the health and well-being of this vulnerable population is critical. Living in poverty is associated with heightened risk of exposure to toxic stress. Toxic stress exposures can lead to severe and chronic reactions, including physiological, emotional and cognitive dysregulations that can alter development across the life span and influence development of future generations (Evans et al., 2007; Seeman, et al., 2010; Shonkoff et al., 2010). Effects apparent at the individual level interact with family level dynamics, and become systemic as the impacts spread throughout the family system and, ultimately, society.

Researchers in the resilience and trauma fields are making steady progress at understanding the cumulative and cascading effects on individuals of coping with the chronic stress associated with poverty. Although comparable research on the family system is lacking, a review of the clinical and research literature on the impact of urban poverty on the family system (individual child or adult, adult intimate partnership, parent-child, siblings and intergenerational relationships, and the family as a whole) demonstrated that all levels of the system make significant and often dysfunctional adaptations to cope with the contextual and situational demands of this social ecology (Collins, et al., 2010; Kiser & Black, 2005). For example, solid empirical evidence suggests that high stress conditions experienced by caregivers diminish parental functioning, and in many cases, undermine parent-child relationships. Findings indicate strong and consistent associations between high stress and parenting distinguished by insensitivity, lack of responsiveness, withdrawal, low warmth, reactivity, irritability, negativity, and harsh, punitive discipline or physical abuse. Decreased positive affective engagement between parent and child is just one consequence of harsh parenting influencing parent-child relationships.

Given the systemic impacts, Kiser and colleagues at the Family Informed Trauma Treatment Center have formulated a model of the complex adaptation processes that tend to characterize highly distressed families under chronically stressful circumstances. Experiencing constant stressors requires equally constant efforts to maintain balance and families must expend a disproportionate share of their scarce resources for coping. They also have few opportunities for recovery. Over time, the wear and tear of the family's efforts to cope may result in maladaptation and dysfunction. Within the model, for example, family unit level changes are characterized by concerns such as systemic dysregulations and altered family schemas or patterns of organizing information. At dyadic or subsystem levels, stress reactions disturb reciprocal patterned interactions altering subsystem processes. Families must also contend with the varied and often non-synchronous reactions of each individual family member.

These complex family adaptations to living under chronically under-resourced and harsh circumstances have multiple effects including disrupting basic family functioning and increasing individual vulnerability to the effects of stress. Such negative adaptations limit the opportunities for families to engage in positive interactions and to experience safe and supportive exchanges. In addition, these relational and systemic effects jeopardize the capacity of families to effectively use structured treatment approaches and underscore limitations to the traditional focus on individual treatment approaches (Gewirtz, Forgatch, & Wieling, 2008; Roberts, Kitchiner, Kenardy, & Bisson, 2009). Families are important resilience and healing supports for individual family members. When overall family functioning is impaired, tackling the symptoms and problems experienced by individual family members is much more difficult. Family systems approaches that

Poverty and Trauma continued on page 10

Poverty and Trauma continued from page 9

improve coping and help families reduce daily hassles and stressors are needed.

Strengthening Family Coping Resources (SFCR) is one example of an intervention developed to help families cope with exposure to chronic stress, multiple traumas, and on-going threats. SFCR uses a multi-family group format to link family level, coping skills development with trauma treatment components addressing the systemic impact of trauma and the ecological impact of chronic poverty. Results from open trials suggest SFCR is a feasible intervention with positive effects on children's trauma-related symptoms (Kiser, Donohue, Hodgkinson, Medoff, & Black, 2010).

SFCR uses a behavioral, skill-building approach that teaches constructive coping resources to strengthen a family's protective function potentially vulnerable to chronic exposure to chronic stress and trauma (Temple, 1997). By enhancing family coping resources, SFCR addresses specific goals including helping family members feel safe, rapidly stabilizing family and individual functioning with appropriate behavioral expectations and limits, co-regulating emotional and behavioral expression, developing a shared positive and prosocial worldview, using problem solving techniques for minimizing additional stresses and exposures, and connecting family members to appropriate supports (Miller, 1999). One advantage of this strengths and skills-based multi-family group intervention is its ability to increase positive connections and social support within and amongst families.

Integrated with the coping skill development, SFCR focuses on physiological, cognitive, behavioral, affective, and social mechanisms that influence the critical symptoms of stress-related disorders. Research generally affirms the effectiveness of phased approaches that include psychoeducation, anxiety management training, affect regulation skill development, and cognitive therapy followed by direct exploration of the traumatic experience, evaluation and reframing of cognitions, and support (Cloitre, Stovall-McClough, Miranda, & Chemtob, 2004). In SFCR, these treatment components are delivered in a novel format that successfully engages all family members in the healing process and simultaneously addresses the pathology that often co-exists in multiple family members and in the family's adaptation to trauma. For example, due to avoidance, numbing, or difficulty knowing how, traumatic events or highly stressful circumstances are rarely discussed in families. Over the course of SFCR, families engage in a series of storytelling activities that gradually lead to identifying stressors and traumas that have not been sufficiently processed and co-constructing a family trauma narrative (Kiser, Baumgardner, & Dorado, 2010).

This manualized intervention was developed to address the needs of families who are multiply traumatized and living in chronically harsh circumstances. SFCR's focus on scaffolding and boosting coping resources offers an opening for families to use their own practices, beliefs, values, and cultural contexts to improve their protective function and develop shared meaning for adverse family experiences. It allows families an opportunity to understand the complex adaptations that they have made to survive their life conditions and to make new choices about how to cope in the future. Through encouraging positive modifications in important aspects of the family's daily life, families who complete SFCR experience contextual change within their family milieu. By building up family resources, including improved coping and family life skills, intergenerational relationships, and social support networks, families begin to mobilize their resources to reduce the downward spiral of resource loss while building needed protection against continued exposure and negative adaptation to chronic stress (Hobfoll, Freedy, Lane, & Geller, 1990; Vazsonyi, Pickering, & Bolland, 2006). Contextual change in the family supports generalization of positive results to all family members with the prospect that positive effects that could be seen across generations.

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Poverty and Trauma continued on page 11

Poverty and Trauma continued from page 10

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Members on the Move: *Carll Re-Appointed*

Dr. **Elizabeth Carll** was re-elected for a second term as Chairperson of the United Nations NGO Committee on Mental Health. The primary mission of the Committee is the promotion of psychosocial well-being, the improvement of mental health care services, and advocacy and education in the prevention of mental illness, globally. Advocacy also includes focus on the inclusion of mental health in the various UN agendas. She is also an ISTSS representative at the United Nations.

Do you know of ISTSS members who have been recognized for significant achievements?

Please send announcements to Editor Patricia Kerig, p.kerig@psych.utah.edu, for the *Members on the Move* feature.

Saying Goodbye and Hello

Anne P. DePrince, PhD
Traumatic StressPoints, Editor

With this issue, I come to the end of a five-year term as Editor of *Traumatic StressPoints*. Saying goodbye has caused me to pause and reflect on the myriad changes for *StressPoints* over the last five years.

When I took the helm, *StressPoints* publication increased to six issues per year and had only recently switched over from paper to an electronic format. With thoughtful feedback from members, input from contributing editors, and conversations with ISTSS leadership and headquarters, we made several significant changes to create an electronic format that worked better for members. For example, we converted to a single PDF format, which can be downloaded and read offline. We made accessing the newsletter from your email easier.

These changes resulted in several good outcomes. Our readership has increased substantially from the early days of our electronic transition. In turn, we are now receiving more unsolicited submissions than at any point in the last five years, indicating that members are reaching out to *StressPoints* as a vehicle to share their work and ideas. In recent years, the newsletter has delivered interesting, high quality articles on a range of topics from diverse authors from around the globe. We have increased coverage in some areas; for example, bringing readers more frequent articles that address child/youth development concerns as well as a steady increase in voices from outside the United States.

Those of you who have come to count on finding articles about Media Matters and Research Methods have continued to see high quality articles regularly. New features have graced your *StressPoints* pages, including Members on the Move and the Book Corner. And our longest continuous-running feature, Trauma and World Literature, brings new perspectives *each and every issue* by reminding us of the humanity of our work – the tears, laughter, grace, sadness, and transcendence that somehow all mingle at the heart of traumatic stress work.

I have left several wishes for *StressPoints* undone. For example, I had wanted to start a feature where readers let us know how you're using *StressPoints*. Do you send it to graduate students to read? Have you ordered books for your own reading or for a class or a client because of the Trauma and World Literature column? I, for one, assign several articles as supplemental readings in my undergraduate teaching. For example, students in my Research Methods course read Fran Norris and Paula Schnurr's (2007) article, "Preparing manuscripts for statistical review" as they learn about manuscript writing and Carl Auerbach's (2007) article, "An introduction to qualitative research methods for studying trauma" to help them understand the complementary nature of qualitative and quantitative research. I hope that you, too, have found the articles in *StressPoints* useful in many, innovative ways.

In saying goodbye, I would like to highlight the incredible work of the people who, most often behind the scenes, make *StressPoints* what it is. First and foremost, thank you to the truly incredible team of contributing editors. These are the unsung heroes who seek out authors for the terrific content in the newsletter. I have had the honor of working with many contributing editors over five years and I've been grateful for the mark that each of them has left on *StressPoints*. I would also like to thank ISTSS Marketing Communications Manager Lindsay Arends who is a jack-of-all trades when it comes to *StressPoints*, pulling together news items, copyediting, doing layout and otherwise keeping many balls in the air at once. And finally, thank you to ISTSS leadership, from board members and presidents to executive director Rick Koepke, for their contributions to *StressPoints'* success.

With goodbye, though, usually comes hello…and that is the case here too. I am delighted to offer my welcome and congratulations to incoming Editor, Dr. Patricia Kerig. Take a few minutes to read about Dr. Kerig in this issue. I am eager to see the directions that StressPoints takes under her leadership!

Kerig Appointed Editor, *Traumatic StressPoints*

The Executive Committee appointed Dr. Patricia Kerig as the new editor of *Traumatic StressPoints*.

Dr. Kerig is Professor and Director of Clinical Training in the Department of Psychology at the University of Utah. Her research focuses on family processes that contribute to the development of (or protection against) psychopathology. She has long-standing interests in understanding and ameliorating the effects of interparental conflict, family violence, maltreatment and parent-child discord.

Her current research focuses on understanding the relationship between trauma and juvenile delinquency; investigating risk and protective processes for maltreated children; and studying the intersections among family dynamics, personality, and dating relationships in adolescence and emerging adulthood.

Dr. Kerig brings important editorial experience to this leadership role. She has served as an editorial board member or associate editor of several journals and has acted as a guest editor for special issues she developed for three journals. In addition, she has edited or co-edited several books.

"One of the reasons I am drawn to helping with this newsletter is the excitement that I feel every time I see it in my email inbox," says Dr. Kerig. "I know that I will be kept abreast of the most interesting and important developments in the field and will learn new information that will help to inform my research and applied work. *StressPoints* is by far the most informative and useful newsletter I receive from any professional organization, and I would be pleased to have the opportunity to contribute to maintaining that level of quality for my colleagues in the field."

Congratulations and welcome to Dr. Kerig!

An Overview of Molecular Genetics for Traumatic Stress Researchers

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Recent advances in molecular genetics have simplified sample collection and lowered the cost of genotyping, and subsequently have led to a drastic increase in the number of psychiatric genetic investigations. Increased attention to genetic factors in the etiology of posttraumatic stress disorder (PTSD) and other psychiatric conditions has also followed. From a clinical standpoint, genetic research may ultimately inform our understanding of risk for PTSD, allowing us to target those at highest risk in specialized prevention programs. Similarly, understanding the genetic mechanisms underlying PTSD onset and maintenance may inform the development of novel pharmacological treatments, such as those designed to enhance treatment gains for difficult-to-treat individuals undergoing cognitive behavioral interventions.

The purpose of this article is twofold: first, to provide an overview of molecular genetic methodology for traumatic stress researchers; and second, to highlight a few central issues and developments in this line of research. This article is

Molecular Genetics continued on page 14

Molecular Genetics continued from page 13

not meant to provide an exhaustive review of either the literature on genetics of PTSD, or on genetically informed research methodologies, but instead aims at highlighting key findings and issues that are central to the conduct of state of the science genetic studies. The interested reader is referred to review articles on genetics of PTSD (e.g., Cornelis, Nugent, Amstadter, & Koenen, 2010; Afifi et al., 2010), more detailed articles on genetics for social scientists (Dick, Latendresse, & Riley, 2011), and methods texts (Neale, Ferreira, Medland, & Posthuma, 2008).

Molecular Genetics

Available twin and family studies indicate that PTSD is moderately heritable, with approximately 30% of variance accounted for by genetic influences (e.g., Stein et al., 2002). Molecular genetic studies seek to identify the specific variants in the human genome that differ among individuals and contribute to this heritability. One of the two most commonly studied forms of variation, or polymorphisms, are single nucleotide polymorphisms (SNPs, pronounced "snips"), which occur when a single nucleotide in the DNA sequence is altered, forming different alleles (i.e., various forms of a genetic locus). A second type of polymorphism is the variable number tandem repeat (VNTR) polymorphism, which is comprised of segments of repeated base pairs, forming various alleles of different lengths. Put very simply, gene-finding efforts are aimed at the identification of sites across the genome where a form of an allele is present in a higher percentage of cases versus controls. We will briefly review the primary methodological techniques utilized, as well as provide recommendations for PTSD researchers interested in incorporating molecular genetic techniques into their own investigations.

Candidate gene association studies use extant research (e.g., information about the putative function of a particular gene, theory or knowledge about the pathophysiology of a condition) to guide selection of genes, which are then tested for potential associations with the disorder. As such, association studies show promise for investigating genetic influences on PTSD etiology, as informed by existing theoretical and biological models, such as fear conditioning. As one example, it has been hypothesized that corticotrophin-releasing hormone (CRH) system genes and binding proteins may mediate the relationship between a highly stress-reactive temperament and HPA axis dysregulation under the conditions of a PTE (Amstadter, Nugent, & Koenen, 2009), and indeed, variation in the *CRHR1* gene was associated with PTSD symptoms in a sample of pediatric injury patients (Amstadter et al., 2011). In another investigation, the "s" allele of the *5-HHTLPR* gene was related to greater incidence of PTSD in both European and African Americans, particularly among individuals with childhood adversity and/or adult traumatic events (Xie et al., 2009). Similarly, 4 SNPs on the *FKBP5* gene, which is related to glucocorticoid receptor regulation, have been shown to interact with levels of childhood trauma in predicting adult PTSD symptoms (Binder et al., 2008). There have been at least 30 candidate gene studies of PTSD to date, including study of over 10 different genes, with varying success (Cornelis, et al., 2010). Candidate gene studies are by definition limited by the quantity, and quality, of information about the underlying biology of a condition. Numerous early candidate gene studies have only genotyped one polymorphism in a gene, which is no longer state of the art. This approach to candidate gene studies would be akin to assessing PTSD with a single question that only queries one symptom and makes a diagnosis of PTSD positive or negative based on that one response. Researchers can use known information such as linkage disequilibrium (LD; whereby certain variation tends to co-occur) to better inform the selection of markers within a gene to assay to maximize the coverage of a gene. Further, emerging paradigms include interrogation of genes across a known biological pathway.

Caution must be exercised when conducting candidate gene studies. It can be tempting to focus study on genes that are known to be associated with a number of different disorders. Although markers like the *5-HTTLPR* may indeed be associated with PTSD given PTE exposure, selecting only the commonly studied regions or polymorphisms (i.e., the "usual suspects"), may not be the most effective or state of the science way to investigate genetic risk for PTSD. Instead, researchers are urged to consider other key findings from the molecular biology literature on stress response and PTSD to nominate genes to study, as well as stay abreast of findings that will soon be

Molecular Genetics continued on page151

Molecular Genetics continued from page 14

coming down the pike from genome wide association studies (see below) to inform gene selection, and then urged to utilize LD to inform marker selection across the gene.

Genome-wide association studies (GWAS) adopt an agnostic approach, testing possible associations between markers across the entire genome in relation to the phenotype. Over the recent years the cost of GWAS chips (panels developed to sample 500,000 – 2.5 million SNPs) have decreased substantially, and the number of markers, and advances in optimal selection of markers, has grown substantially. Although GWAS studies require large sample sizes of cases and controls, GWAS chips are commercially available, suggesting that researchers interested in this approach could easily add DNA collection to new protocols with comparable environmental measures and later do a joint analysis across studies. This exciting approach has the potential to identify important, previously unconsidered genetic influences on health and psychology as well as to reinforce the relative importance of previously studied candidate genes. In addition to possible cost preclusions, GWAS studies are complicated by the sheer number of tests and the statistical "hit" that is taken for correction for multiple testing.

Whether an investigator chooses to employ a GWAS or a candidate gene study, *gene-environment interplay* is particularly important to consider for disorders such as PTSD that are contingent on an environmental event. Gene-environment interplay involves investigating the relationships between various genetic and environmental factors as they relate to a particular phenotype and includes two primary approaches: gene-environment interaction and gene-environment correlation. Gene-environment interactions (GxE) can be thought of in terms of the genetic variation modifying the relationship between environmental exposure (e.g., a traumatic event) and the phenotype (e.g., PTSD), or the environment modifying the effect of genetic variation on an outcome.

GxE investigations are important for better understanding a complete picture of PTSD etiology and maintenance, and subsequently, our ability to intervene clinically. For example, if a particular variant is implicated in PTSD risk, but only under certain environmental conditions (e.g., low social support, high environmental stress), prevention programming may be individually-tailored through genetic markers. PTSD researchers with expertise in behavioral and environmental measurement are invaluable in efforts to understand gene-environment interplay by helping to refine environmental and phenotypic measurement in genetic studies.

Gene-environment correlation (rGE), on the other hand, refers to the extent to which individuals create and influence their own environments (e.g., Rutter, 2010). In other words, rGE reflects the passive and active ways in which an individual's genotype influences their subsequent environment. With regard to stressful and traumatic life events, Kendler and Baker (2007), in a systematic review of genetic influences on environment, found the heritability of negative life events to be 39% and that for traumatic event exposure to be 36%, with overall heritability across environmental measures estimated to be approximately 27%.

Incorporating Molecular Genetic Methodologies into PTSD Research Programs Participants. Researchers interested in incorporating genetic methods to their research are advised to seek collaborators who can provide the expertise necessary as related to study design, data collection method, and data analysis. However, we will outline a few key considerations for incorporation of genetic data collection to PTSD research. In addition to the practicality that PTSD cannot be diagnosed in the absence of PTEs, it is especially critical for genetic researchers to consider participant exposure to PTE given evidence that: genetic factors may influence likelihood of experiencing PTEs, symptom severity increases linearly with increasing numbers of traumas, and different trauma types are associated with different rates of PTSD (e.g., natural disasters; Cisler et al., 2011). Additionally, factors such as gender and ancestry (i.e., race) are important in new ways in genetic research as some genetic variation may reside on X chromosomes, may exert varied effects across gender, and may be more or less common across groups of different genetic

Molecular Genetics continued on page 16

Molecular Genetics continued from page 15

ancestry, referred to as population stratification.

DNA collection. As this article is a brief overview of incorporating genetics into PTSD research, we will not go into extensive detail about DNA collection protocols, but we would like to raise awareness that there are three main ways to collect DNA: 1) a peripheral blood draw, 2) buccal cell collection via a cheek swab, and 3) saliva collection. While all of these sources provide a high enough DNA yield for most analyses, each method has advantages and limitations.

Questions to Ask Your Genetics Collaborator. We hope that this article highlighted some of the critical issues in the field of molecular genetics of PTSD. We are aware that we are only touching on the tip of the iceberg, so to speak, and due to space limitations we have left out many important topics to consider. We also are aware that the fields of molecular and statistical genetics are rapidly evolving and that the state of the science may change. Therefore, we provide a list of potential questions below for those who are interested in adding a genetics component to an upcoming study to consider:

- Is my planned study conducive to a genetics component (e.g., sufficient sample size, inclusion of adequate control groups)?
- What genotyping method should I use (e.g., candidate gene, GWAS, sequencing)?
- What type of sample do I need to obtain DNA (e.g., buccal cells, saliva, blood) and how long can I store the samples?
- How do I decide how much of the sample I need to produce ample quantity and quality of DNA for my study?
- How do I obtain informed consent for genotyping?
- How do I deal with issues of participant gender and ancestral background?
- How much does genotyping cost?

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Mental Health and the UN General Assembly Declaration on Non-Communicable Diseases

Elizabeth K. Carll, PhD
Chair, United Nations NGO Committee on Mental Health

Non-communicable Diseases (NCDs) are defined by the United Nations General Assembly (UNGA) as consisting of four main global chronic diseases, including cardiovascular disease, cancer, diabetes and respiratory illnesses. These diseases are expected to become an increasingly enormous burden on society in the next 10 to 20 years and are rapidly evolving into an epidemic, particularly in lower income nations. This mushrooming epidemic led to the historic UNGA Summit on NCDs. In addition, according to the World Health Organization (WHO), depression is expected to be the number two chronic disease burden worldwide by 2020 and number one by 2030. Depression is a factor in the course of many chronic diseases as is trauma. Depression leads to poorer outcome in the treatment of cardiovascular disease and often is co-morbid with chronic illness.

The UN NGO Committee on Mental Health in New York, a consortium of non-governmental organizations (NGOs) partnered with The NGO Health Forum in Geneva, a network of NGOs, to focus advocacy efforts on the 193 countries of the UNGA for the inclusion of mental health in the Declaration of the UNGA Summit on NCDs. Mental health was successfully included in the UNGA Declaration on NCDs as a risk factor for prevention and control of NCDs. This success would not have been possible without various mental health and supporting groups also focusing on lobbying member states.

The Joint Statement of the NGO Forum on Health and the NGO Committee on Mental Health titled "Mental Health and the Scope of Non-Communicable Diseases", available in English, French, and Spanish, including the list of endorsing NGOs, can be found at http://www.mentalhealthngo.org/content.html?page=10. Ninety-four NGOs endorsed the statement.

In addition to the four chronic diseases addressed by the UNGA, advocacy resulted in the successful inclusion of the rapidly increasing neurological disorders such as Alzheimer's and dementia included in the paragraph referring to mental health.

As a result, the Declaration included "that mental and neurological disorders, including Alzheimer's disease, are an important cause of morbidity and contribute to the global NCD burden for which there is a need to provide equitable access to effective programmes and health care interventions."

Outcome

The recognition of mental health as a risk factor for NCDs has been agreed to by 193 countries. This is an important outcome as previously mental health has not been recognized by many countries as a significant factor affecting health and social and economic development requiring action. While the WHO has become increasingly cognizant and supportive of the role of mental health in health care and in social and economic development and mental health has been mentioned in some documents and resolutions, the UNGA Declaration on NCDs is intended as an action document with follow up in 2012 for implementation targets. As indicated by one of the supporting government health ministers, mental health is now at the table, even if it is at the edge.

It appeared to be the general consensus of the UNGA that the first line of prevention and control of NCDs will be through primary care. There are references to primary care in the Declaration and frequent references in the verbal statements of the representatives of the 193 countries throughout the Summit. Therefore, mental health can be expected to be an integrated component of primary care health delivery groups and systems globally.

Obviously, the implementation of the terms of the Declaration will be key. Since the Declaration was an historic first step and did not include measurable performance targets, this will be the next step. As stated by Margaret Chan, Director-General of the World Health Organization, "what is not measured does not get done." The NGO Committee on Mental Health, and the NGO Health Forum and other organizations will focus advocacy on the implementation steps to accomplish what was established in the UNGA Declaration on Non-Communicable Diseases.

Elizabeth Carll, PhD, was re-elected as chair of the United Nations NGO Committee on Mental Health and is a member of the ISTSS UN team.

Upcoming Events

November 3 - 5, 2011
"Social Bonds and Trauma Through the Lifespan"
ISTSS 27th Annual Meeting with Pre-Meeting Institutes Nov. 2
Baltimore Marriott Waterfront
Baltimore, Maryland, USA

March 28 - 31, 2012
"Being a Healing Presence in a Hurting World"
Association for Death Education and Counseling (ADEC)
34th Annual Meeting
Atlanta, Georgia, USA

April 12 - 15, 2012
"Integrating Mind-Body Connections: Advancing Science, Informing Practice for Anxiety and Related Disorders"
Anxiety Disorders Association of America (ADAA)
32nd Annual Conference
Arlington, Virginia, USA

April 20, 2012
"Emerging from the Heart of Darkness: Guided Imagery and Breakthroughs in Healing Post-Traumatic Stress" Workshop
Grace and Growth Counseling Center
Mercer University
Atlanta, Georgia, USA

May 23-26, 2012
World Congress on Traumatic Stress
Centro Banamex
Mexico City, Mexico

November 1 - 3, 2012
"Beyond Boundaries: Innovations to Expand Services and Tailor Traumatic Stress Treatments"
ISTSS 28th Annual Meeting with Pre-Meeting Institutes
October 31
JW Marriott Los Angeles at L.A. LIVE
Los Angeles, California, USA

Visit the ISTSS website for more upcoming events, continuing education opportunities and ISTSS news!