



Contents

President's Message
page 2

Stop Violence Against Women
Amnesty International
pages 3 – 7

In Dafur – Western Sudan
UNICEF
pages 7 – 8

Thierry Baubet Interview
Médecins Sans Frontières
pages 9 – 10

Chapter News
pages 11 – 13

News
page 13

Trauma in the System
page 14

EMDR in the Treatment of PTSD
page 15 – 16

New Psychotherapies for PTSD
page 17 – 19

BSFF in the Treatment of PTSD
page 19

Trauma Classics
page 20 – 23

Conference Calendar
page 24

Stress Points

Newsletter for the Australasian Society for Traumatic Stress Studies

Editorial

Welcome to a bumper edition of Stress Points for your winter reading.

In this issue we explore the theme of women and trauma in an unconventionally broad perspective. We launch the issue with Amnesty International's campaign to stop violence against women around the globe. This is followed by two reports from front line medical personnel working with women and their children in trauma ridden areas.

We then turn the focus inward to our own mental health system and its treatment of trauma victims, most of whom are women. In an article somewhat inspired by Nin Thomas's contribution last edition, Jennifer Davis writes about working within the current health system and its frustrations. One of these frustrations is a reluctance to engage psychotherapies for the sequelae of traumatic events. This brings us to three articles presenting different therapies for PTSD.

Winter 2004

I would like to thank Suzy Clarke and Maria Nguyen from [Amnesty International](#), James Nichols from [Médecins Sans Frontières](#), and Pam Garcia from [UNICEF](#) for their efforts and time in bringing their organisations' wisdom to this edition of Stress Points.

The regular features of [President's Message](#), [Chapter News](#), [Trauma Classics](#) and [Conference Calendar](#) return.

As always we invite you to submit contributions in the form of short papers (no more than 1,500 words), Book Reviews and Letters to the Editor which address traumatic stress, especially the upcoming themes of domestic violence and trauma in the arts. Email your contributions to: B.Tarrant@latrobe.edu.au, or mail to

PO Box 4011,
Balwyn East,
Victoria,
Australia, 3103.

Bronwyn Tarrant



PRESIDENT'S MESSAGE

by John Raftery

26 June, United Nations International Day in Support of Victims of Torture, reminded us of the enormous global well of trauma we have built up.

We have been so bombarded with the revelations of torture in the Iraqi Abu Ghraib jail, that these have somewhat detracted from the 10th anniversary of the horrendous day of genocide of women and children in Rwanda, one of the blights on our humanity in the 20th Century. The massacre signified a complete breakdown of the values of a civilization that somehow protects us from our own potential for destruction. As Fergal Keane, a BBC journalist who returned to the sites of the terrible scene he had witnessed in April 1994, stated in a recent broadcast, that the most vulnerable in our society become the victims of political and social violence. On his return he observed the adults and adolescents who had been severely injured and traumatised ten years earlier. They were still living with their physical and emotional scars in a community still experiencing daily violence.

Closer to home, the recent revelations in Australia of sexual abuse in various church organisations reminded us that: (1) a

breakdown in the values that protect the young and the vulnerable from the abuse of those in power, and (2) sexual abuse, are an ongoing trauma. Almost every week there is another revelation of such abuse, and some states are now examining the safeguards we have in place to protect the most vulnerable.

Both of these violations of fundamental human rights remind us of the necessity of a society like ours. Along with other organisations we have a duty to take a stand against such violations, as well as to ensure that those damaged by various forms of violence are provided with optimal chances of recovery. We have an obligation to make sure that we do not repeat the same mistake of treating all such abuse a form of mental illness that must be dealt with in a private and confidential manner. For this reason I welcome the contributions of NGOs like Amnesty International, which not only reveals the unspeakable but urges us all to take public action against violence and abuse.

AMNESTY INTERNATIONAL AUSTRALIA

STOP VIOLENCE AGAINST WOMEN

Worldwide one in three women is subjected to violence in their intimate relationships.

In Australia, the figure is one in four, with 35 percent of women in Australia experiencing violence from their partner *after* separation.

In the United States, one in three women faces the threat of sexual assault. In France, less than a quarter of rapes are reported because of the stigma attached to rape. In Switzerland, a woman is at greater risk of violence in her own home than she is on the streets. In the UK, emergency services receive an average of one call per minute dealing with violence in the family.

How much misery and fear is masked behind the phrase “domestic dispute” allowing us to cover up the brutal reality of violence in the home? How many times does the joke about having walked into a door cover the reality of a fist in face? Why is it still true that domestic violence

is the major cause of death and disability for women in Europe between the ages of 16 and 44 years, accounting for more deaths and ill-health than cancer or traffic accidents?

Amnesty International and the Stop Violence against Women campaign

Violence against women is a hidden scandal of our times, but it is as real in its effects as any cancer, eating away at the core of every society, in every country of the world.

To break the silence, on 8 March, International Women’s Day this year, Amnesty International Australia launched its Stop Violence against Women campaign at Parliament House – an appropriate place, since it is within the walls of parliament that political accountability begins.

Amnesty International, a global non-government, non-partisan organisation of over 1.5 million people, has been working for

more than 40 years to promote and protect human rights. In response to the changing human rights landscape, the organisation has broadened its mandate beyond the traditional civil and political rights to encompass economic, social and cultural rights.

Stop Violence against Women is the first major campaign to be launched, reflecting this broadened scope. It is a six-year global initiative that addresses domestic and family violence as a human rights issue, and it is one that touches on every country, every society, every social class and every community – during times of war and peace.

As part of the global Stop Violence against Women campaign, Amnesty International is calling on governments, corporations, and individuals to accept their role and responsibility in preventing or condoning violence against women.

We are committed to exposing violence against women and the governments, systems and cultures that allow such violence to go unchallenged and unpunished. Changing attitudes is at the heart of this campaign.

Why violence against women continues

More than 60 million women worldwide are 'missing' from the population because of female infanticide and gender-selective abortions, while violence against girls and women is used as a weapon of war in conflicts around the world.

Millions of women and girls are genitally mutilated in the name of custom. Tens of thousands of women killed in the name of honour.

Human rights violations against women are allowed to happen because laws, policies and practices discriminate against women – politically, economically and socially. They are a direct result of inequality and impunity, originating in power and prejudice, and sustained by apathy and upheld by misogyny.

As of last year, 54 countries maintain laws that actively discriminate against women. 79 countries have no law against domestic violence. 127 countries have no laws against sexual harassment.

Human rights violations against women happen because governments turn a blind eye to violence against women and allow impunity to the perpetrators. They continue to occur because dominant ideas about gender roles reinforce the power of men over women's bodies and lives.

Community and religious leaders reinforce roles, attitudes and customs which seek to subordinate and subjugate women and perpetuate violence against them. Whether at the hands of Christian, Islamic or Hindu fundamentalists or even football clubs – a common casualty of culture, tradition and practice is women's rights.

Human rights violations are allowed to happen because of the feminisation of poverty – growing numbers of the poor are women, and women living in poverty are more exposed to

violence, and less able to escape it.

Violence against women is *everyone's* business

Violence against women happens because we all tolerate it. Women are too afraid or ashamed to speak of it and men deny it. The rest of society looks away and in doing so colludes with the perpetrators. It is easy to see why.

Other people's private relationships are not our concern, we tell ourselves. Intervening will only make it worse. Perhaps she had it coming, even deserved it. If it was so bad she would leave.

I didn't mean to hit her, it is only because I love her, she led me on; are the all too easy refrains from men.

Why do women accept this treatment? Bruises heal and maybe it won't happen again; the family needs to be kept together; it's the same for others and men will never change. Who can I talk to and where would I go?

Every act of violence is a step away from a relationship of trust and respect; a family damaged, mental and physical health ruined. We are all diminished for looking the other way.

Domestic violence is reported as the leading cause of premature death for European women aged between 15 to 44. In Australia women who are subjected to violence have increased levels of anxiety, addictions, cervical cancer, suicide rates, mental health problems, homelessness and poverty. The majority of violated Australian women do not report their abuse and remain silent.

Violence against women is not confined to any particular culture, economic group or country. It is prevalent in every country across the world and cuts across boundaries of wealth, race and culture. It is not something that happens to other people, it happens to us, to our friends, our mothers, our sisters, and our colleagues.

In Australia, one in four women suffers violence in their intimate relationships. 73 per cent of refugee women coming to

Australia in the 1990s had experienced torture and trauma; sexual assault was nearly always part of their ordeal.

Violence against women as a human rights issue

In working to promote awareness of this scandal, one of the major achievements of women's rights activists has been to demonstrate that violence against women is a human rights violation. This changes the perception of violence against women from a private matter to one of public concern and means that public authorities are required to take action.

Framing violence against women as a human rights issue creates a common language for the work of anti-violence activists and facilitates global and regional networks. These networks are taking their own governments to task, and instigating new international legal standards and practices.

The explicit inclusion of rape as a war crime and crime against humanity in the statutes of international criminal tribunals exemplifies these new standards. Such standards signify an increased commitment on the part

of the international community to end violence against women and to bring perpetrators to justice.

The human rights framework also specifies governments' obligations under international law to promote and protect women's human rights. It provides mechanisms for holding governments to account if they fail to meet these obligations.

Stop Violence against Women conference: Donna's story

In January this year, Donna Carson was named as an Australian of the Year Local Hero. For the crusade to end violence against women, Donna Carson represents the courage we need to embrace. One Friday afternoon, Donna, then a school teacher and young mother, was in her kitchen, her children playing outside, when her husband doused her in petrol and set her alight. Against all odds of survival, with burns through to the bone to over 65 per cent of her body, Donna underwent 19 operations and is today an advocate for victims of crime, burns survivors and survivors of domestic violence.

Speaking at Amnesty International Australia's Stop Violence against Women conference in June, Donna

told us how, having survived her horrific ordeal, the worst was yet to come. The NSW Department of Community Services told Donna she would never see her children again, she was an unfit mother because she had allowed her children to witness violence. Nine months later her children were returned. She sued the Department and subsequently won her case.

Donna realised that the court system was flawed. In local courts, victims were sitting next to their alleged offenders being pressured to drop charges. This prompted Donna to establish a safe waiting room at the Taree Court House for women and children, particularly those in domestic violence cases. At the safe waiting room, women now receive support as well as a safe place away from their abusers.

Donna's story is important because it reminds us that each of us can make a difference, each of us can break the silence and speak out to stop violence against women.

It is unacceptable that one in four women in Australia experience violence in their

relationships. We must build a community of human rights defenders at every level of society, who are prepared to denounce violence against women and be prepared to combat the systems and cultures that enable violence against women – inequitable power relations, economic dependence, diminished career and education opportunities, cultural attitudes of disdain for women and the all pervasive culture of silence and tolerance, which allows perpetrators to commit violence against women with impunity.

Too often, those in our community who oppose violence against women do little to combat it. We need to change the culture of silence that accepts violence against women as a private matter. Human rights violations can only be stopped when we, as a society and as individuals, expose them. This applies to whether women are violated in Bosnia during a war or in Australia in the workplace or the home.

As long as the perpetrators of violence against women can commit their crimes without fear of being exposed and made

accountable, the cycle of violence will continue.

Making human rights a reality for all women

For every two seconds that have passed while reading this article, somewhere in the world, a woman has been the victim of a serious act of violence.

Through our Stop Violence against Women campaign, Amnesty International is calling on leaders, organisations and individuals to make human rights a reality for all women. We are demanding the abolition of laws which discriminate against women and perpetuate violence. We are insisting that governments adopt and apply laws effectively to protect women and criminalise rape and other forms of sexual violence. We are campaigning to end impunity for violence against women, no matter where it happens, in the bedroom, the board room, the back street or the battlefield.

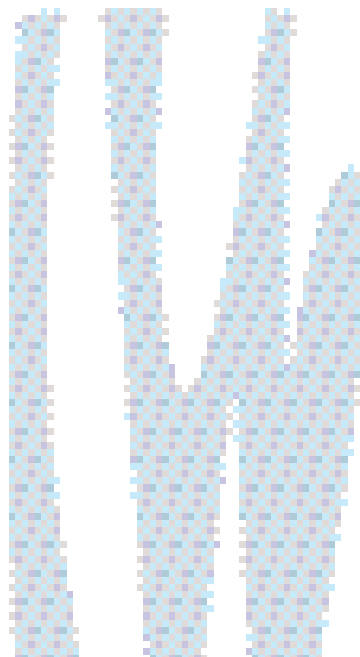
Our campaign is not only about what governments must do. It is also about what society and we as individuals must do to change attitudes that discriminate

against women, belittle women and encourage violence.

On the 4th to 5th of September, Amnesty International Australia will hold its inaugural annual human rights conference, *'Human Rights: A Pacific Agenda – Partnerships and Perspectives'* in Brisbane. Here, the crime of violence against women will again come under the spotlight, as will other critical human rights issues. The conference is open to everyone. To attend, or for further information about the conference and the Stop Violence against Women campaign, visit www.amnesty.org.au.

Violence against women is not acceptable and it is not inevitable. It is in our hands to stop it. By supporting Amnesty International Australia and its campaign, you are pledging to make human rights a reality for all women.

compiled by Maria Nguyen



UNICEF in DAFUR – WESTERN SUDAN

With hundreds of thousands of weary and ailing women and children arriving in make-shift camps across the dry Sudanese state of Darfur, the rapid provision of water and sanitation services is critical.

James Elder visited a camp in western Darfur, where new arrivals have led to a 1,200 percent increase in the population, though where UNICEF's interventions are turning the balance in favour of life.

DARFUR, 16 June, 2004 – At the foot of an immense, bare mountain, surrounded by miles and miles of sparsely wooded flatlands, Mornei village was a model place to live in the savannah of western Darfur. The village comfortably sustained 5,000 people. But over the past nine months, ferocious attacks on scores of farming villages across western Sudan have forced an additional 60,000 people to take refuge in Mornei.

One of the most populated Internally Displaced People (IDP) camps in Darfur; Mornei is now more mess than model. Thousands of unsteady grass huts – the lucky few with plastic sheeting for roofing – have sprung up at the foot of the mountain. The ground is scorched – a sign of too many people trying to feed themselves; and the children are uncomfortably thin. With local resources – water, sanitation and food – stretched beyond breaking point, the health and well being of tens of thousands of people are at risk.

“In this sort of situation, with unbearable stress on water and sanitation services, a massive outbreak of water-borne diseases is our greatest concern,” says Vishwas Joshi UNICEF Sudan’s Water and Environmental Sanitation Project Officer.

UNICEF began operations in Mornei in March and after tireless work these past 150 days the UN Children’s Fund is just one week away from supplying clean water to every single IDP in Mornei. This has been combined with massively boosted sanitation systems – 570 latrines and counting – and training scores of hygiene promoters.

It is UNICEF’s three-pronged attack to control water-borne diseases and to reduce the stress on IDPs. The water pipe will not only provide clean water to more than 60,000 people (when I was in Mornei local authorities reported an additional 10,000 IDPs had arrived in the past weeks), but the pipe will also safeguard women. For it is the women who have to venture further and further away from the settlement in search of water. Many have been attacked. Some have been raped. All are tired and frightened.

At the same time UNICEF and its counterpart, the state branch of the National Water Corporation, have trained more than 100 hygiene promoters to liaise with their own people and communities, delivering ‘hygiene packages’ of soap, jerry cans and blankets, and imparting essential information on sanitary habits and health. Darfur has never been an area terribly well serviced in the health sector, and so UNICEF is seeking to save lives today, and empower people for tomorrow.

Asma Wahid is a UNICEF hygiene promoter in Mornei who says she has entered “hundreds of homes”, and believes the message is getting through. “I continue to find a lot of malnutrition and diarrhea,” she says, crouching in the straw door of a home no more than two metres by two metres. “I advise them on how to keep good sanitation in these hard conditions. And I am starting to see things improving, and importantly people are starting to talk to each other about these issues.”

Following Asma as she goes from home to home, past hundreds of people now idle with no farms to tend, we come to the home of Yonis Ibrahim, his wife Khadega, and their two small children. Still nervous after surviving a brutal attack on their village, Khadega is at first unsure of the visitors and hesitant to accept anything from strangers (she fears the soap may be poisoned). But after some calming words from Asma, the family sits down with her and listens to her advice.

Once living relatively well in their village of Mandiga – Yonis owned land and some cattle – they lost everything when their village was ransacked and burnt. “Here we have nothing,” says Khadega. “My husband has no work, my children have too little food, and the place is not clean.”

As we leave, Khadega takes my hand and expresses a flurry of ‘thank yous’ in her native tongue. She has been given three bars of soap. Imagine her pleasure when UNICEF provides clean water to her and 60,000 like her.

Better still, imagine her joy when her family is able to return home and restart their lives. Security issues mean that is still some time away, and until then UNICEF’s resources in dozens of camps across Darfur are extremely stretched. Only with continued and heightened international support will UNICEF continue to be able to improve conditions for women such as Khadega in camps like Mornei. The alternative is too grim to consider.

James Elder – June 16th 2004

Australian working for UNICEF in Dafur

MÉDECINS SANS FRONTIÈRES

INTERVIEW WITH THIERRY BAUBET

Médecins Sans Frontières (Doctors Without Borders) provides emergency medical aid to the victims of natural and man-made disasters, famines, epidemics and conflict. Every year the Australian section of the organisation recruits around 100 medical professionals to work as volunteers in the field, including a number of psychologists.

Médecins Sans Frontières is the world's largest independent medical aid organisation. Every year it sends 3,000 volunteers to some 80 countries around the world, where they work alongside 15,000 locally recruited staff. The following interview regarding provision of mental health care in violent settings was first published in the Médecins Sans Frontières newsletter, *Messages*.

Why should a humanitarian organisation provide mental health intervention?

Treatment for physical illness doesn't always speak to the range of problems that people who have suffered emotional trauma experience. Some find it extremely difficult to resume normal life and anticipate and prepare for the future. This issue can even limit the effectiveness of regular medical care. For example, between the two intifadas, an NGO established a nutrition program in the Palestinian territories, but many babies still did not gain weight. MSF intervened at that point, providing short-term home psychotherapy visits with about 400 pairs of mothers and children. As a result, three-quarters of the children reached normal weight. Their poor nutritional status was linked to depression and/or post-traumatic stress that they and their mothers were suffering.

When and where does Médecins Sans Frontières conduct mental health missions?

Our interventions occur primarily in situations of extreme violence. It can be very difficult for people to endure a situation in which one group carries out organised violence against another, as in Kosovo, Chechnya, the Congo Republic, and the Palestinian territories, for example. That's when we discover the human potential to commit horrible acts. Natural disasters are another form of extreme violence that can also cause trauma. Our latest mental health mission is currently under way in Algeria, where we are providing aid to victims of the earthquake in the eastern part of the country. Finally, we also intervene in situations of social exclusion, such as in Madagascar, where we have a program for children and adolescents, and in China and America. I would like to clarify that MSF's psychologists and psychiatrists never intervene alone. MSF programs always include a medical component and, sometimes, a social work component.

What problems do you encounter among victims in these situations?

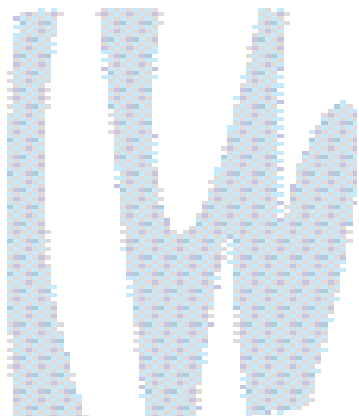
After a traumatic event, some people experience particularly acute suffering that does not ease with time. These problems may have a serious effect on their daily lives and lead to severe distress. Most patients who present with post-traumatic problems suffer from traumatic flashbacks. That is, they relive the incident with the same level of distress they experienced at the time. I remember a man who was telling me his story when he suddenly became unable to speak. Patches of eczema broke out all over his body. Some people try to adopt avoidance strategies to escape their memories. They don't sleep, stop going to work so they don't have to leave the house, stop thinking (which is particularly serious among children because it interrupts their intellectual development), and dull their emotions

with alcohol and mood-altering drugs. Many suffer from depressive symptoms, which can range from loss of self-esteem to suicidal impulses. Finally, trauma victims always have a sense of guilt (with respect to themselves) and shame (with respect to others). Most do not speak openly or freely about their trauma, which makes it that much more difficult to overcome.

An NGO can provide only short-term treatment. Isn't that too limited to be helpful?

Short-term therapy can help to deal with post-traumatic disorders. I don't mean to suggest that it can resolve all issues, but it does allow victims to emerge from what we might call a state of "emotional paralysis" that prevents them from thinking about anything except their trauma. It helps them to resume their lives. In Kosovo, we treated children who had been taken out of school because they were agitated, refused to sleep, and screamed all night. After five or six sessions, they were able to sleep again and return to school, even if they remained anxious.

**Interview by Rémi Vallet with Thierry Baubet,
Psychiatrist and Consultant
Médecins Sans Frontières' Medical Department**



Advancing Traumatology: From Violence, Trauma and Human Suffering to Healing and Hope

10–11 September 2004
Marriott Hotel, College Street, Sydney

The 2004 ASTSS conference will explore: Violence on Women and Children; Innovative Interventions, International, Regional and Local Violence and Trauma; Trauma and Physical Injury; Trauma and Mental Illness; and Trauma and Memory. Presenters include:

Paul McGeough, New York based writer-at-large specialising in international conflict

Mary Harvey, Department of Psychiatry at Harvard Medical School, and Director of the Cambridge Hospital Victims of Violence Program

Sandy McFarlane, Department of Psychiatry at the University of Adelaide and Senior Advisor in Psychiatry to the Australian Defence Force

Patrick McGorry, Department of Psychiatry at the University of Melbourne, and Director of ORYGEN Youth Health and ORYGEN Research Centre

Caroline Taylor, Victorian Law Reform Commission's Advisory Committee of Sexual Offences, and the University of Ballarat

Richard Bryant, Department of Psychology, the University of New South Wales

Colleen Jackson, Director of the Sisters of Charity Outreach, Tasmania

Grant Devilly, Crime Victims & Incident Recovery Research Group, Swinburne University

Stephanie Hodson, Australian Defence Force Mental Health Strategy

Janet Haines, School of Psychology at the University of Tasmania.

Judy Atkinson, Southern Cross University
Ulrich Schnyder, Uni Hospital Zurich

CHAPTER NEWS

WESTERN AUSTRALIA

There is great enthusiasm about the 2005 Conference.

It will be a steep learning curve for us and we hope to gain much from the Sydney conference in September so that we may overcome some of the difficulties we are likely to encounter.

In W.A. the need to deal with child abuse has become a political issue. The indigenous member for parliament for the Kimberleys, Carol Martin, tabled that there were many cases of sexually transmitted disease in children in the Kimberleys. In fact, there were nine cases of children under the age of 5 and 80 cases in children under the age of 16 reported recently. In total there were over 200 cases in children in Western Australia according to the media. Clearly this is only the tip of the iceberg.

One area that is of great concern is the effect on adult survivors of childhood abuse giving evidence in court. Recently after two trials, which resulted in hung juries, a perpetrator was released, even though he had many prior convictions. The victim refused to go to trial for a third time as she could not cope with the symptoms of her P.T.S.D. This has informed the public about some of the victims' difficulties, and the problems of law enforcement and management of predators. We hope to deal with some of the spectrum disorders related to child abuse in the 2005 Conference.

At the same time as we are working towards the conference we are also doing what we can to build the infrastructure and maintain momentum.

Dulcie Veltman
dveltman@upnaway.com



VICTORIA

The last few months have seen a period of change for the Victorian Chapter. The AGM in April became the time marker for saying goodbye to the President Roslyn Chandler and long serving committee member Jennifer Helmich. Both have many years of hard work and contributions to ASTSS behind them. (Please visit the Victoria Chapter Website for Minutes and Reports given at the AGM.) The AGM was followed by a stimulating talk generously given by Ruth Wraith on 'Child Trauma - Current Issues, Challenges and Directions for Treatment'. She reminded us of the complex task of integrating trauma, treatment, services and policy, and also provided a structure focused on ways of obtaining future treatment objectives. Members from the Sudanese Community attended and contributed to question time. The meeting included ample refreshments, hopefully as an enticement for yet more members to attend the AGM on an annual basis.

The Victoria State Award for Research in Traumatology was awarded to Tania Pantchenko for her submission: 'Verbal and non-verbal disclosure of childhood abuse and its effect on psychological and psychophysical well-being: Relationship to trauma and psychological dissociation'.

Committee: Jitka Jilich is our new President and two new members Michelle Roberts and Cait McMahon have joined the committee. We had a Planning Afternoon where new and not so old committee members became acquainted on an informal basis and fuelled by wine and wonderful cheeses we brainstormed together, resulting in a number of areas of interest which seem worth pursuing. Through discussion it emerged that there exists

some lack of clarification for committee members about the ASTSS role with respect to being more proactive in the field of trauma as compared with that of promoting research and education for Members. We will continue to discuss this issue and to seek clarification as ideas for future activities evolve.

Education Programme

Study Discussion Group: 'Trauma and the Brain Introductory Level' has completed six fortnightly meetings. A core group of six participants stood the test of neurological seminars, reading homework and discussion. Use of videos namely Van de Kolk and a TV production 'Primal Instincts' provided visual dynamics relating to this intellectually challenging topic. This was the first of what is hoped to be an ongoing series of Study/Group Discussions with one more series being planned for this year; the topic is still under discussion. Thanks to Bronwyn Tarrant for the generous use of her rooms as the venue.

Paul Valent will present his Traumatology Seminar Series. This series comprises of 12 sessions in August/September 2004. Dates: **August** Saturday 7th and 28th all day and Tuesday nights from 7pm to 9pm on 10th, 17th, 24th, 31st, **September** 7th and 14th. For content details and information on this very worthwhile Seminar Series please visit the ASTSS Victorian Chapter Website or contact Jitka Jilich at: jitka.jilich@communityconcepts.com.au

Future Events: In September 2004 Dart Australasia - Centre for News Media and Trauma Symposium will be held in Melbourne. Cait McMahon is caretaking this event and Victoria Chapter will assist with the organisation. Attendance is free and details will be advertised as soon as they become available.

Our Annual Dinner and Study/Discussion Group are as yet in the planning stages. We are in the process of putting into action ideas formulated at the Committee Planning Afternoon. Please visit our website or contact Jitka Jilich (email above) or Felicity May for further information on Victoria Chapter activities.

Ethel Tillinger, Victoria State Representative has taken a well deserved leave of absence until the end

of 2004. Felicity May will act as State Representative during this time.

Felicity May
fmair@ozemail.com.au



NEW SOUTH WALES

The Sydney Chapter met on June 8, 2004. There was some general discussion and then I gave some feedback from the Management Committee Planning Meeting in Melbourne in April.

We formed an interim committee: Beth A Stone, NSW Representative, (beths@psych.usyd.edu.au); Peggy Lee, (plpsyfirst@hotmail.com); George Dieter, (georgedieter@netscape.net); Jennifer Suneson, (jsuneson@psych.unsw.edu.au). Further, Jennifer Suneson volunteered to be Treasurer. We're sure Lynda Matthews will be glad to turn over the books to Jennifer before she takes on the job of President of ASTSS.

Presentation:

I presented my work on a Nonverbal communication tool, The Pictured Feelings Instrument or PFI. The PFI includes a validated Nonverbal Vocabulary of Feelings: 26 line drawings of facial and bodily expressions of 26 feelings on user-friendly cards. The feelings range from happy, sad to left out, victim, winner, entrapped, etc. The group looked at the different methods for using the PFI, including simply choosing the feeling cards the person is feeling most: a body image format; or a card sort in boxes marked from feel a great deal to hardly ever. If anyone wants an abstract, please contact me or check the ASTSS web.

We hope that you and others will come, offer suggestions for topics, and/ or offer to present a case, an issue, a method. Please contact me.

Beth Stone
beths@psych.usyd.edu.au



WESTERN VICTORIA

The Western Victorian Chapter held an immensely interesting night on June 1, 2004. We were addressed by Lou Tehan, a creative arts therapist from Stawell in Victoria. She works with ABI cognitive disability clients and uses an eclectic approach involving art, drama, music, story telling and text enactment. She describes her work with these clients as "counselling with an aesthetic dimension".

In her direct but compassionate style she explained that when there is "a broken head, a splattered brain and blurred vision the healing and transforming

power of non verbal art is amazing". And many of these are young people who tragically and horribly have lost their career, their partner in many cases and their medium for expression of their ideas. It is a social death.

We are conducting a further seminar in August on the traumas associated with adoption.

Daniel Torpy
Chairperson
West Vic Chapter

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NEWS

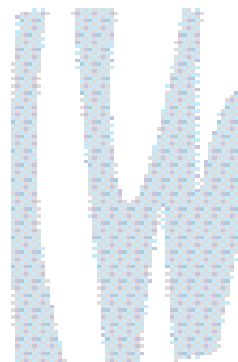
AFMA and ASTSS Members

A number of members have recently been sent a letter from Australian False Memory Association. That letter was soliciting support and indicated that AFMA knew that the recipients were members of ASTSS. The letter was sent without any authorisation or endorsement from ASTSS. It appears that the organisation may have gained access to the ASTSS database that is only available to members through our Member Only link. This was indicated by the fact that at least one letter was sent to a home address which only appeared on our database.

Subsequent to receiving the letter I contacted the signatory of the letter by telephone and asked how ASTSS addresses were obtained. She did not know, and I asked for the matter to be investigated. I then sent a formal letter of complaint from ASTSS, requesting further clarification. I have not received a reply.

Members will be kept informed of this matter, but I wish to point out that the ASTSS Executive and Management Committee regard this as a very serious breach of our privacy and will continue to pursue AFMA and take appropriate action. If it is found that a member of ASTSS has provided the details from our database, the ASTSS Executive will take disciplinary action as required in our Constitution.

John Raftery – President ASTSS



TRAUMA IN THE SYSTEM

by Jennifer Davis

My years working as a Psychologist in both an outpatient and in-patient setting within the public mental health system was filled with contradictions. On the one hand, there were severely traumatised women and men who would come to the unit hoping for safety, and on the other, a system ill-equipped to assist these people to find some form of safety and to recover. Clients would generally find themselves on the “acute side of the ward” after a crisis and period of self-harm and/or anger directed at a partner, children or the Police. Some clients were clearly in dissociative states and others full of rage and terror at being “locked up”. The periods of admission varied greatly and seemed to depend on the ‘patient’s behaviour’. If the patient was well-behaved and fitted in with the routine of the ward, they were discharged sooner than if they showed ‘regressed’ and ‘disruptive’ behaviour toward other patients and staff. However, being locked up in close proximity with other patients who are acutely psychotic has major implications for a trauma survivor. First of all, they have had their freedom of person taken away (mostly for very sound reasons – nevertheless it can feel like the situation of abuse all over again) and they are room-mates of the pretty terrifying and bizarre behaviour one associates with acute psychosis.

One of my severely abused ‘BPD’ (I prefer complex PTSD) clients who had a long and entrenched history of admissions was dragged by her hair from her bed in the middle of the night by a psychotic female room-mate and beaten up. Most staff and patients who are in the acute section of a psychiatric ward suffer abuse at the hands of aggressive patients with psychosis. For the trauma survivor patient, this violence further overlays the violence already experienced and reinforces that there is no safety to be found anywhere, thus fuelling the cycle of acting-out and regressive behaviour which is punished by over-stretched and

under-trained medical staff. This same patient was refused discharge until she agreed in writing to an injection of an anti-psychotic medication, which was to be used as an anxiolytic. Trauma patients can be very difficult, but staff who bully patients into submission have lost control and are perpetuating an extremely flawed system.

Upon ‘recovering’ and leaving the ward, the situation rarely improved. The client was allocated to the first available case-worker who could be a registered nurse or one of three allied-health professions. No training was given regarding therapy for trauma survivors, and in fact therapy itself was discouraged because it was seen as getting ‘over-involved’ with the client. All that was encouraged was semi-regular contact to ensure that the client was taking his / her medication post-discharge. We were instructed by one team leader to fit in as many home visits in a day as we could, as clients really needed no more than 15 minutes with us at a time. That team leader is still within the system and has since received a promotion to a position of significant power and influence.

I countered that situation by working to the beat of my own drum. I studied everything I could on trauma and dissociation and took annual leave to attend the seminars of Judith Herman, Bessel van der Kolk, Allan Schore and others. I had to take annual leave as the topic of trauma was deemed as not being relevant to my work as a Psychologist within the mental health system. Taking this work seriously within this context necessitated a certain amount of isolation, which is absolutely anathema when dealing with a traumatised population – as is using one’s annual leave for anything other than recreation. I carried out some of the best, and most satisfying, work of my career, but became so distressed by the system and from isolation and despairing that it would ever change, and got out.

The system remains largely unchanged since I was there. It is a massive drain on the country's limited financial and human resources. There are some basic changes that could be made, however some are financially challenging because of the way the current psychiatric hospitals have been built. Trauma survivors without psychosis should not be hospitalised with those who are psychotic. Trauma survivors should receive treatment from professionals who are trained and interested in their 'condition'. There should be a system of therapy in place so that crises and admissions are managed and planned and do not continually surprise and further traumatise the client. More training is needed for staff at all levels within a psychiatric ward in how best to respond to trauma survivors. We need a health system that recognises there are many disadvantaged trauma survivors who cannot afford private health insurance and who therefore do not have access to professional trauma recovery programmes.

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EMDR IN THE TREATMENT OF PTSD: A RETROSPECTIVE OF A PATIENT AND THERAPIST

by Aimee Jo Martin

EMDR (Eye Movement Desensitization and Reprocessing) is a therapy often used in the treatment of PTSD. During EMDR the patient focuses on emotionally disturbing experiences while simultaneously focusing on an external stimulus such as eye movement or finger-tapping. This dual (internal/external) focus is combined with frequent, brief periods of focusing on new

associations as they arise. Throughout the therapy, the therapist methodically rates the patient's SUDs (Subjective Units of Disturbance) on a scale of 0 - 10, ("0" being the lowest amount of stress the patient is presently experiencing about the target issue; "10" being the highest); and VoCs (Validity of Cognition) on a scale of 1 - 7, ("1" being the lowest amount of belief the

patient holds in a specific positive statement about himself; "7" being the highest amount - ie: the positive statement is "completely true.")

Just how well does EMDR therapy work in the treatment of PTSD? What degree of patient improvement is made on a daily or weekly basis? For a therapist who only sees a patient

approximately once a week, how does the therapist judge the degree of improvement made between office visits? Often it is difficult for a therapist to determine patient improvement, as it is not the therapist who is personally experiencing the EMDR process.

This retrospective study compares a patient's perception of her status throughout the EMDR process, paralleled by her therapist's evaluation of the results of EMDR therapy.

PATIENT HISTORY IN BRIEF: The patient in this study was severely beaten and raped at the age of seventeen years. Attempting to forget about the attack, she was plagued with Post Traumatic Stress Disorder (PTSD), eating disorders, feelings of depression, rage and distrust for the following fifteen years, despite her considerable professional accomplishments. In 1999, she finally sought professional therapy. After reviewing her history and having the patient's mood stabilized with the use of an antidepressant medication, the therapist recommended EMDR therapy. This therapy lasted approximately nine months (March 2000 to December 2000), after which cognitive-behavioral therapy completed the therapy process.

DATA UTILIZED: During the EMDR process, the patient maintained a personal, daily journal, documenting her life, as well as her perception of her progress throughout therapy. The journal was intended originally to be a personal item: not something to be shared with others. Although an ongoing chronicle, the journal dates utilized in this retrospective

study are between September 1999 and January 2003.

The therapist data were abstracted from customary EMDR worksheets and her clinical notes of this patient's emotional status throughout the therapy process.

METHOD: The data were compiled and compared in May 2003. The patient retrospectively divided her journal entries into three stages: Pre-EMDR; Middle Stages of EMDR; and Post Stages of EMDR. She further categorized her general daily mood into three types of days: Positive-emotion day (a day in which she mostly felt happy, calm, confident, energized, able); Neutral-emotion day (a day in which she mostly felt apathetic, confused, numb, nonchalant); Negative-emotion day (a day in which she mostly felt angry, fearful, sad, hopeless, defeated). The therapist data were divided into six EMDR target issues: rape; body image; self-confidence; family invalidation; feelings of unworthiness; and feelings of shame. Each target issue was measured utilizing the Subjective Units of Disturbance (SUD) and Validity of Cognition (VoC) scales, both before and after EMDR therapy.

The data were then compared to determine whether the patient's decrease in negative-emotion days and increase in positive-emotion days correlated with the therapist's findings of decreased SUD ratings and increased VoC ratings after EMDR therapy.

FINDINGS:
PATIENT'S PERCEPTION OF DAILY MOOD (Figure 1)

Time Frame	+ve days	neutral days	-ve days
Pre-EMDR	6.2%	32.5%	61.5%

Middle Stages of EMDR	23.6%	37.5%	39.0%
Post Stages of EMDR	83.0%	13.0%	4.0%

THERAPIST'S FINDINGS (Figure 2)

EMDR Target Issue	SUD (start)	SUD (end)	VoC (start)	VoC (end)
Rape	9	.25	1	7
Body Image	9	1	1	6
Self-Confidence	10	1	1	6
Family invalidation	9	2	2	6
Feelings of Unworthiness	10	1	2	6
Feelings of Shame	9	1	1	6

CONCLUSION: Although this study was limited to only one patient's and one therapist's perspectives, it appears to be the first of its kind reported. After extensive research, this team was unable to locate earlier reports of findings where therapist and patient records were maintained independently and later compared, regarding the outcome of EMDR therapy.

The present findings of this study indicate that the therapist's perception of patient improvement and patient success throughout the EMDR process parallels the patient's perception of self-improvement and success.

This report is continuing from the patient's perspective (and, if future EMDR therapy is necessary, therapist's) to determine the longevity of success.



WHY NEW PSYCHOTHERAPIES FOR PTSD?

by Ulrich Schnyder

*This article first appeared in **Stress Points** and is reprinted here with permission from **ISTSS***

The efficacy of psychotherapeutic and pharmacotherapeutic approaches in the treatment of PTSD can be regarded as empirically demonstrated (Foa et al., 2000; Livanou, 2001; Sherman, 1998). Overall, effect sizes seem to be higher for psychotherapy as compared with medication (van Etten and Taylor, 1998). Psychotherapy for PTSD includes the following approaches:

Cognitive-Behavioral Therapy (CBT) uses a variety of techniques such as exposure, cognitive processing and restructuring, stress inoculation training, assertiveness training, and relaxation techniques. CBT usually is offered as a time-limited psychotherapy, averaging approximately eight to 12 sessions, with meetings once or twice weekly. Many well-controlled trials with a mixed variety of trauma survivors have demonstrated that CBT is effective in treating PTSD (Foa et al., 2000; Foa and Rothbaum, 1998; Foa et al., 1991; Marks et al., 1998; Tarrier et al., 1999). More specifically, exposure therapy currently is seen as the treatment modality with the strongest evidence for efficacy (Foa et al., 2000).

Eye Movement Desensitization and Reprocessing (EMDR) is a technique in which the patient, under the guidance of a therapist, carries out horizontal eye movements while he or she recalls the traumatic scenes. Although the clinical efficacy of this technique has been well documented, EMDR still remains controversial. A meta-analysis revealed that EMDR is similarly effective in comparison to other exposure techniques but that eye movements in particular have no incremental therapeutic effect (Davidson and Parker, 2001).

Psychodynamic Therapy seeks to reengage normal mechanisms by addressing what is unconscious and, in tolerable doses, making it conscious. This is

accomplished by exploring the psychological meaning of a traumatic event. It may include sifting and sorting through wishes, fantasies, fears and defenses stirred up by the event (Foa et al., 2000). Transference and countertransference, and the therapist-patient relationship, are crucial factors in this approach. Although varying in length, psychodynamic therapy is usually of longer duration than CBT. Unfortunately, only few empirical investigations with randomized designs and validated outcome measures have been reported (Brom et al., 1989), so currently there is no sufficient evidence indicating that psychodynamic therapy is effective in reducing PTSD symptomatology.

Brief Eclectic Psychotherapy (BEP) has been proposed by Gersons and collaborators as a fully manualized, multimodal treatment approach that combines educational, cognitive-behavioral and psychodynamic elements. It comprises five essential elements: 1) psychoeducation; 2) guided imagery (exposure); 3) writing assignments and mementos; 4) the domain of meaning and integration; and 5) a farewell ritual. BEP proved to be effective in reducing PTSD symptoms in police officers suffering from chronic PTSD, as compared with a wait-list control group (Gersons et al., 2000). In addition, the improvement demonstrated for PTSD symptoms progressed further in all outcome measures, including return to work, three months after termination of treatment. However, these promising results need to be replicated independently, applying BEP in more general trauma populations.

There is no doubt that psychotherapy is an effective component in the treatment of patients suffering from PTSD. Why then should we keep searching for new psychotherapeutic approaches? Here are some reasons:

* Dropout rates from studies of CBT usually are around 20 percent (Ballenger et al., 2000). Up to 58 percent of patients who completed CBT are still

diagnosed with PTSD at posttreatment assessment (Resick et al., 2002; TARRIER et al., 1999). Furthermore, only 32 percent to 66 percent of patients included achieved good end-state functioning (Marks et al., 1998; Resick et al., 2002). Therefore, alternative therapies should be tested so that patients can be offered different treatment options.

* There is a high probability of PTSD becoming a chronic condition. Although some patients recover spontaneously from PTSD – mainly during the first year after a trauma (Kessler et al., 1995; Rothbaum and Foa, 1993) – and others undergo treatment, the mean duration of PTSD episodes amounts to several years (Ballenger et al., 2000; Kessler et al., 1995). Thus, treatment for PTSD should not focus exclusively on specific symptoms, such as flashbacks and avoidance, but on basic life changes and existential questions as well since such issues are of relevance for patients who suffer from chronic PTSD.

* In many intervention studies, highly selected samples are treated with a one-dimensional, highly structured treatment protocol in a university setting. This is justifiable from a methodological viewpoint. However, such a procedure reduces the complexity of a therapeutic process in such a way that it becomes uncertain whether the results can be translated into the everyday experience of a psychotherapist in private practice. Psychotherapy research, therefore, should start evaluating multimodal, integrative treatment protocols that do justice to the various aspects of posttraumatic psychiatric morbidity in realistic clinical settings.

The incidence of traumatic events is increasing worldwide, confronting us with cycles of violence that are becoming more destructive. Further research into the devastating consequences of traumatic events and, even more urgent, into the development of more effective therapeutic interventions aimed at ameliorating trauma-related psychiatric disorders is of utmost importance.

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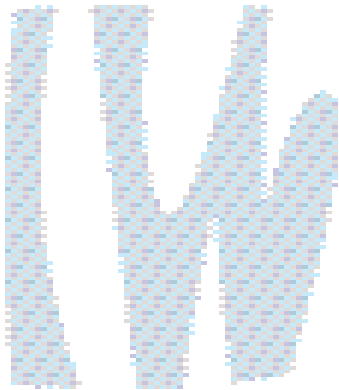
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BSFF in the TREATMENT of PTSD

by: Dennis Shum

I would like to share with your members my experience with a novel psychotherapeutic procedure for the resolution of emotional trauma.

This procedure is developed by USA psychologist Larry Nims, who calls it "Behavioural & Emotional Symptom Elimination Training For Resolving Excess Emotion of Fear, Anger, Sadness & Trauma", or "BSFF".

BSFF specifically directs the clients' focus away from ruminating about their past, and towards exercising their intention towards removing traumatic emotions and releasing hidden blame through the mental act of forgiving.

Since learning it in 1999, BSFF has become my preferred treatment procedure for emotional trauma, over EMDR and hypnotherapy. Clinically, it seems to be exceptionally useful in resolving all forms of emotional trauma, from acute stress reaction to chronic PTSD. It addresses emotional, psychodynamic and spiritual needs simultaneously. It is quick, gentle, thorough and is perceived by clients to be natural.

Because the BSFF procedure does not involve a historical narration of traumatic memories by the client, it keeps abreaction of emotions to a minimum. This is a major advantage over other methods.

I now routinely use BSFF to address clients' emotional problems, and use cognition and behavioural approaches to cover the rest. In my view BSFF deserves a good look and proper clinical outcome research. Being brief, easy to learn, focussed and easily manualised, it is ideally suited for such research.

Dr Dennis Shum is a Psychiatrist in private practice

TRAUMA CLASSICS

by Andrew Moskowitz

MARDI HOROWITZ'S "STRESS RESPONSE SYNDROMES" (1976)

Mardi Horowitz's seminal book, Stress Response Syndromes, published in 1976, significantly impacted the formulation of the posttraumatic stress disorder category in the DSM-III (American Psychiatric Association, 1980), released four years later. On the broadest level, what Horowitz set forth in his book was that – despite differences in nuance between responses to different stresses – such as armed combat, accidents, rape, etc. – there were also significant similarities. Prior 20th century trauma books, such as Kardiner's Traumatic Neuroses of War (1941) and Eitenger's Concentration Camp Survivors in Norway and Israel (1964), had all focussed on specific trauma populations. In contrast, Horowitz argued that all stress response syndromes included phases of intrusion and avoidance (which he referred to as denial), with differences in degree and timing. This formed the core of the DSM-III PTSD diagnosis.

Mardi Horowitz, in 1976, was perhaps the first of a breed of psychological scientists, most recently seen in Allan Schore, who attempted to integrate psychodynamic theory with contemporary cognitive or neurocognitive perspectives of PTSD. While this sometimes makes a rather odd mix, all in all, he succeeded rather admirably. Stress Response Syndromes is now in its 4th edition, and Horowitz has gone on to write a number of other books on PTSD and psychodynamic psychotherapy, as well as devise the popular *Impact of Events Scale*. He is on staff at the Langley Porter Neuropsychiatric Institute, teaches at University of California at San Francisco and – as I discovered while cruising the net – paints for relaxation.

Stress Response Syndromes lies solidly in the psychoanalytic tradition; indeed, it forms part of a series entitled, "Classical Psychoanalysis and its Applications", and includes, in many sections, historical overviews of relevant psychoanalytic theory. The book is structured in a somewhat unusual way. Discounting the brief introduction and conclusion, there are four parts. In the first, entitled, 'Stress Response Syndromes', Horowitz introduces the broad concepts of intrusion and denial with a clinical case, then follows with chapters on clinical, field (i.e., war, rape, concentration camps, etc.), and experimental findings supporting his position. This section ends with a rather impressive (for its time) series of research studies, in which Horowitz and colleagues exposed subjects to films of traumatic (and non-traumatic) events, and then assessed the prevalence of intrusive experiences, while varying almost all variables that could potentially affect the results (e.g., instructions, population, distractor tasks, etc.).

The second part is entitled, 'General Theory' and lays out (in rather excruciating detail), his cognitive-analytic conception of how traumatic events are processed under various circumstances, and general approaches to treatment. In the third part, entitled 'Individual Variations', Horowitz discusses ways in which certain personality types – hysterical, obsessional, and narcissistic – vary in their responses to trauma (varying the fictional clinical case, 'Harry' to fit the types) and suggests interventions to deal with each personality type. Finally, the last and easiest to read section consists of real-life clinical examples, with extended transcripts from

therapy sessions interposed with explanations of the therapist's interventions.

Horowitz introduces 'Harry' early on – a truck driver carrying steel pipes who picked up a hitchhiker shortly before having a car accident, in which the hitchhiker was impaled by one of the pipes and died. Not surprisingly, Harry develops a 'stress response' and seeks treatment. Importantly, in addition to highlighting phases of intrusion and denial, Horowitz emphasises the importance of significant themes – or as he calls them 'complexes of ideas and feelings' – such as guilt over causing the girl's death, guilt over sexual fantasies experienced before the accident, 'survivor' guilt, fear about mortality, irrational anger at the hitchhiker for 'causing' the accident, fear about having broken company rules (by stopping for a hitchhiker), etc. Horowitz believes that all relevant themes require attention and ideally 'working through' in order for treatment to be successful.

While Horowitz's work is often cited as proposing an alternation of phases of denial and intrusion in stress reactions, he is clear that these phases are often not pure and discrete.

Warding off thoughts about the stress event, or its implications, may alternate with intrusive repetitions in a variety of phasic relationships. Denial and numbness may characterize a given time span of hours or days; this may alternate with phases of ideational intrusion and emotional pangs. Also, there may be intrusive repetitions of one aspect of a stress event, with simultaneous denial and numbing of another implication of the event (fear

content intrusions, for example, with repression of guilt-content associations). (p. 21).

After reviewing reports of stress reactions to a wide range of life events in Chapter 4, Horowitz concludes that a general stress response tendency can be delimited. He proposes that there are typically three 'response phases' to stressful events: 1) 'Outcry', which he defines as "an almost reflexive emotional expression upon first impact of unexpected new information", 2) 'Denial', comprising "some combination of emotional numbing, ideational avoidance, and behavioural constriction", and 3) 'Intrusiveness', consisting of "unbidden ideas and pangs of feelings which are difficult to dispel, and of direct or symbolic behavioural re-enactments of the stress response complex" (pp 56–57). A successful resolution of the traumatic responses involves subsequent 'working through' and 'completion'. Even here, however, Horowitz (perhaps indulging in the psychoanalytic defence of 'undoing'?) insists on the flexibility of the process, emphasising that individuals can "enter the abstract sequence of phases at any point and go through the sequence in any order" (p. 59).

In Part Two, Horowitz presents an impressive but complex information processing model of the 'oscillation' between phases of intrusion and denial, and the various factors that may influence it. This is followed by a chapter on general treatment principles, in which Horowitz emphasises the complexity of responses to trauma.

(E)ven speaking in simple generalizations, there will be a multiplicity of themes connected with the stress event during the course of

processing associated information to a point of completion. Any given self-image, as a victim or an aggressor, and any emotional experience such as guilt, fear, or anxiety, will be overdetermined in that not one but several themes may link together to form the image or affect. No stress response is ever a matter of a single conflicted train of ideational and affective response. There are always multiple factors resulting from the mind's tendency to seek similarities and integrations. (p. 115).

Most of what Horowitz discusses as treatment in this section and the rest of the book would best be characterized as brief, focussed, psychodynamic treatment. That is, while understanding that an individual's 'neurotic style' (or personality disorder for non-analytic types) can and should inform the therapeutic approach, which is the primary focus of the next section of the book, Horowitz's emphasis is on completing the processing of the traumatic experience, not modifying an individual's character style. However, he emphasises that this is an option others may wish to take, noting that, "stress events bring character traits and pathology into sharp relief... (and) activate latent conflicts, childhood fantasies, magical thinking, and memories of past stress events," (p. 129) all of which may be therapeutic grist for the mill.

One basic principle of treatment proposed by Horowitz is that the therapist use interventions to modulate experiences of

intrusion and denial – a tactic he refers to as 'dosing' – so as to allow the patient to process manageable 'bits' of information. He summarises his treatment response as follows:

The treatment of stress-response syndromes is centred on the goal of completion of information processing cycles initiated by the stress event. The phase of stress response is recognized by an informed interview for signs and symptoms, and treatment techniques are used according to the current phase, in order to accomplish progressive movement. At times this includes facilitation of warding-off manoeuvres just as at other times the patient will be helped to set aside unconscious defensive operations. Transference and core neurotic conflicts will be a part of the therapeutic work but will tend to be interpreted in terms of their real relationship to the current stress... The nuances of the therapy technique, beyond the general strategies, will depend on the patient's character style (and that of the therapist). (p. 136).

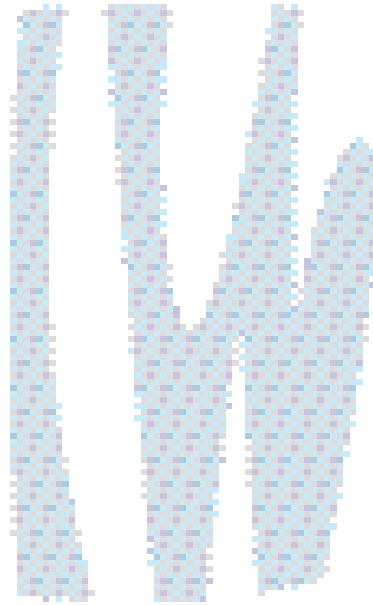
In the next part, he gets into these 'nuances' in more detail, emphasising 'clarity' in individuals with 'hysterical' personalities, 'holding to context' in persons with obsessional personalities, and 'tactful' interventions in persons with narcissistic personalities. Though these may sound

somewhat 'trite', the skill of Horowitz's technique really shines through when he discusses some of these subtleties.

In the last, lengthy (150 page) section, Horowitz presents a number of real-life clinical examples to 'flesh out' the admittedly rather dry preceding sections (in fact, Horowitz subtitles this section 'An Antidote to Abstraction'). Cases involving the loss of a limb, witnessing a violent suicide, a car accident, and the death of a parent, amongst others, are presented in detail, with lengthy transcripts and explanations of therapeutic interventions (or lack of interventions). While no new material is presented here, the clinical cases do help to integrate the wealth of material Horowitz has previously presented, and make compulsive reading. Anyone interested in psychoanalytically-informed trauma treatment would find these case discussions of considerable worth, as they would indeed the rest of the book.

As much of the trauma world, and mental health in general, have moved away from psychodynamic perspectives, writings such as those produced by Mardi Horowitz may be overlooked. This is unfortunate, as there is a wealth of good sound clinical advice in this book, and well-grounded theorizing, from which many people in the trauma field could benefit. Fortunately, Horowitz's book came along in time to influence the editors of the DSM-III; whatever his current impact, we have Horowitz to thank for the core emphasis on intrusion and denial that forms the foundation of our current conception of PTSD.

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Conference Calendar

September 3-5, 2004

6th Annual Conference of the German
Speaking Society of
Traumatic Stress Studies (DeGPT)
University of Vienna
Phone: +1-4277-478-91
<http://www.trauma2004.at>

September 8 - 10, 2004

12th Annual Oklahoma Conference on Child
Abuse and Neglect & Healthy Families 2004
Web Site:
[http://okcdrb.ouhsc.edu/conference/pages/in
dex.htm](http://okcdrb.ouhsc.edu/conference/pages/in
dex.htm)

September 10-11, 2004

11th Annual ASTSS Conference
Advancing Traumatology: From Violence,
Trauma and
Human Suffering...to Healing and Hope
Sydney, Australia
<http://www.astss.org.au>

September 12, 2004

"Be Set Free Fast (BSFF) by Larry Nims"
Presenter: Dr Dennis Shum
Free workshop to ASTSS members
email: donheggie@bigpond.com

September 13-15, 2004

Child Abuse and Neglect Conference
Sacramento, CA
Contact: April Tang 916-734-4719

September 17-22, 2004

Family Violence and Sexual Assault Institute
(FVSAI)
9th International Conference on Family
Violence
San Diego, California, USA
E-mail: fvtrain2@alliant.edu

September 19-22, 2004

9th International Conference on Family
Violence:
Working Together to End Abuse
San Diego, California, USA
<http://www.fvsai.org>

September 28-30, 2004

'Getting it Together: Family Therapy Practice

for the Future', 25th Australian Family
Therapy Conference
Brisbane
Website: www.orgaus.com.au/aft2004

October 1, 2004

Community Crisis
"How to Stay Focused & Effective When
Traumatic Events Occur in Your Own
Community"
Fort Wayne, IN
http://www.parkcenter.org/elizabeth_hess,_ph_d.htm

October 6-9, 2004

8-th International Conference on the
Treatment of Sexual Offenders [ICTSO]
"Sex Offending is Everybody's Business"
Athens, Perifereia Protevousis, Greece
<http://www.iatsoathens.gr/>

October 28-31, 2004

'Trauma and the Transformational
Conversation', 16th Annual Conference of the
Australian and New Zealand Association of
Psychotherapy.
Manly Pacific Sydney
Website: www.anzapweb.com

November 14-18, 2004

ISTSS 20th Annual Meeting
New Orleans, Louisiana, USA
<http://www.istss.org>

November 17-18, 2004

Conference on Innovations in Trauma
Research Methods (CITRM)
New Orleans, Louisiana, USA
<http://www.citrm.org>

November 18-20, 2004

ISSD 21st International Conference Moving
Dissociation into the Mainstream
New Orleans, Louisiana, USA
<http://www.issd.org>

December 7-11, 2004

Models for Healing Multicultural Survivors of
Historical Trauma Conference
Santa Ana, New Mexico, USA
E-mail: TakininetConf@aol.com