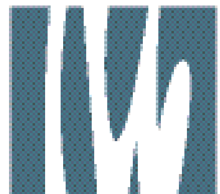

Stress Points

Newsletter for the

Australasian Society for Traumatic Stress Studies

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Editorial

Spring 2005

What is the cost of survival? After a devastation by mother nature how do communities recover? How do we as a community of professionals help surviving communities? How do professionals provide aid whilst witnessing the traumatic aftermath of natural disasters? In this edition of Stress Points we begin to explore these questions.

Dr Rob Gordon, Consultant Psychologist to the Victorian State Emergency Recovery Plan (and a psychotherapist in private practice) explores the impact and management of arousal in providing aid after natural disasters. Cait McMahon, Director of the Dart Centre for Journalism and Trauma – Australasia, gives recommendations for journalistic coverage of natural disasters. Jenny Dawson, a therapist specialising in complex trauma and PTSD who has run workshops in Australia and Africa on trauma related issues, reports on her experience in Sri Lanka after the Tsunami. Tony Taylor looks at trauma response and training of professionals providing that response.

Although the format of the newsletter has changed the regular features of President's Report, Chapter News, and Trauma Classics are still here. Also Elizabeth Sachse outlines planning for the W.A. 2005 conference. The change in format is a trial – to deliver the same hardcopy information at less cost to members. So let us know what you think.

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

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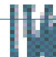


PRESIDENT'S MESSAGE

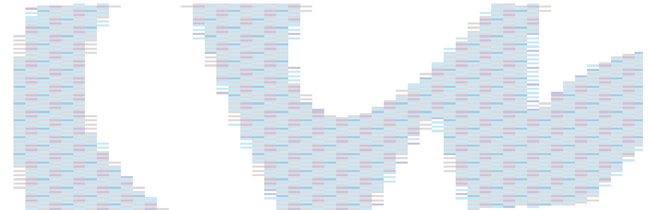
by John Raftery

The Tsunami thundered out of the twilight of Christmas Day, a time when we might expect to be spared of such calamity. This time it was not a terrorist attack, but a freak of 'nature', that caught us by surprise. As has been said many times, the mobilisation of relief and rehabilitation by organisations was spectacular. There was also a preparedness and recognition of the social and psychological impact. The readiness to address this impact may partly be attributed to organisations like ISTSS, ESTSS, and ASTSS that have consistently provided a forum to improve intervention and recovery protocols. While there are still arguments about the merits of immediate intervention and cultural appropriateness of western interventions, many organisations were able to mobilise psychological first aid and begin to implement long term programs. In Australia, there was an existing organisational framework for disaster management that was able to coordinate a response both home and abroad. This system had partly emerged out of response to the Bali Bombings, but their origins go back at least to the Ash Wednesday Bushfires.

A month after Boxing Day I travelled to UK and Netherlands. Everywhere in Europe there are reminders of a traumatic past – the Great Fire of London, the scourge of Black Death, countless ruins from past rape and pillage in the name of political and religious reform; memorials to the World Wars and the Holocaust. At the same time there are the daily updates on current traumatic hot spots around the globe. The ongoing violent struggles in countries like Israel, Iraq and Lebanon somewhat overshadowed another potentially great trauma for the globe. Towards the end of February a scientific report confirmed that global warming was not a fiction, was linked with our levels of consumption, and sooner rather than later would present us with another major traumatic challenge.

Trauma and its aftermath are indeed an 'old species of trouble' and not an invention of the 20th century. However, taking the health consequences of such events seriously *is* an invention of the 20th century. I believe that through our international network with other trauma organisations ASTSS needs to intensify our effort to ensure that trauma and health remain on the global public health and organisational agenda.

Dr John Raftery



NATURAL DISASTERS AND TRAUMA

by AJW (Tony) Taylor

The eye of a storm is neither the place to redesign ships nor to ponder the creation of catastrophe. The crew can or should do nothing but alter course, reduce speed, batten down the hatches, and ride out the turbulence. It is the same for the treatment of widespread trauma from disasters – such as the devastating tsunami on 26th December 2004 that swept across the vast Indian Ocean and wiped out whole communities around the coastal perimeter and on the islands en route. Emergency responders close at hand and early arrivals on the scene could only administer such first-aid – physical, psychological, and social – as that for which they had the training and the resources, while keeping a watchful eye to minimise if not to prevent adversity arising from any secondary effects of either the original catastrophe, such as a shortage of essential medical services, contaminated water supplies, or their own well-meaning but inappropriate interventions. They were also well advised to monitor their own levels of stress and fatigue, because the sheer volume of work to be done far exceeded their ability to respond. They were, and still are, relay runners in a marathon event, rather than sprinters in a short race. They could do little but apply a triage of priority to the work on hand, while trying to scope the enormity of the task ahead and feed-back information to the policy analysts responsible for meeting it.

In turn, as the record of disasters always shows, their colleagues respond with a generosity of spirit that is commendable if not always appropriate. The best are those familiar with the effects of sudden tragedy on members of the general population. They appreciate the significance of the destructive loss of everything that gave meaning and purpose to the lives of individuals, families, forebears, and communities – it was the heritage of social capital of which they were stewards for future generations. The worst are the insensitive clinicians who would attempt to apply inflexible models of psychopathology and its treatment to all and sundry, regardless of need and readiness to respond. Little wonder that some people at large are fearful of professionals being let loose on them!

Like any other sector of the population, health professionals of both kinds – the one compassionate and the other authoritarian – have an urge to converge on disaster sites. After 9/11, an idea was floated for having ‘maverick staging posts’ to which the uninvited might be diverted until their services were required by those in command of the scene. Although the thought originated from the chaos created by the spontaneous arrival in New York

of superfluous firemen volunteers from all parts, there could be merit in applying it to contain overly keen volunteer trauma therapists – especially if it were in the form of a website operated by a duly constituted professional body where registrants might offer their services for a given period, and in the meantime gain access to the latest material on disaster trauma and treatments while waiting to be called.

Apart from updating their knowledge of disasters, the breathing space would give potential helpers time to make the necessary arrangements to cover their personal and professional obligations for the period they might be away, and to consider the official health, insurance, and security advisories, as well as the essential items of clothing and equipment needed for the climate they might be entering. It would also allow them to contact people familiar with the affected region for first-hand information about cross-cultural belief systems and social structures that set the framework within which they might be operating. A crisis does not allow time to reflect on the profound differences between cultures, but it does require outsiders to move with humility and respect, the more accurately to perceive the needs of people they encounter in order to see how they might help to meet them. Once on site they will be able to seek out indigenous helpers to acquaint them with local customs and to help them overcome problems of language, and then work out an appropriate *modus vivendi* for the task ahead.

Potential helpers also need to bear in mind that their own commitments in a given disaster area will mostly be short-term. Realistically the most they can hope to do is administer psychological first-aid in a form that makes sense to those on the receiving end. In the process they could share their concepts and techniques for stress reduction with indigenous helpers, and as far as possible maintain a link with them afterwards to monitor the outcome. They can give comfort, consolation, and support, and help the traumatised gradually to take faltering steps on the road to recovery by helping them to confront their memory blockages before working through the complexities of their grief.

In the process they can accept that others might be able to offer the same assistance, and be careful not to install themselves peremptorily as experts who have all the answers to the problems presented (like Consultants at Grand Rounds in Teaching Hospitals of Medical Schools). To avoid the trap, it helps to have a sense of perspective and a sense of humour – the one providing insights from unexpected quarters, and the other giving temporary emotional protection and necessary bonding to a group under pressure.

Group membership is important for people working under pressure, although it is not necessarily an aspect of clinical work to which practitioners attend. More often they are used to working as individuals in private practice in a chain with others as needed. Long ago at the Tavistock Institute, Wilfred Bion pointed out that leadership, good emotional relationships, and a common working ethos were the

essential pre-requisites for effective group performance, and the lesson he gave needs to be remembered. Transferred to the disaster scenario, leadership requires the ability to liase with local external authorities for a given stint of operation in a specific area, with an adequate minimal level of board and lodging. It involves the readiness to carry responsibility for a working unit, establishing lines of authority and communication for group members, and keeping an eye on their welfare to prevent burnout. Good emotional relationships require group cohesion, mutual respect, and support to be engendered and maintained, none of which can be taken for granted. The recipe for effective performance is completed by a shared commitment to the work on hand, a willingness to take the rough with the smooth, and persistence in the face of hardship and unexpected difficulties.

Then once in operation, there is the question of what basic records helpers should keep of the work undertaken, both for maintaining good professional practice and for being accountable to colleagues and any umbrella organisation for the quality of service provided. Although the exigencies of the moment *in situ* might demand less attention be paid to detail, if left too long the omission could easily degrade into slackness. Here the painstaking work of certain Disaster Victim Identification Units for the dead might offer a lead for the detailed recording of information about the living - particularly if it were to provide an accessible data-base for *bona fide* personnel from organisations in the recovery phase of disasters that would otherwise require casualties to go over the same heart-wrenching details time and again.

Potential helpers proposing to stay home and extend their practice either to traumatised survivors returning from a stricken area or any troubled close relatives that might have identified closely with any casualty living or dead, might not need to pay special attention to fresh cross-cultural considerations. But they will still need to adapt their skills as required for helping the basically sound sector of the population that has been exposed either directly or indirectly to phantasmagoric events. On the job they will encounter casualties with the familiar but transient symptoms of stress who will need support as they confront their horrifying memories and revive their noxious sensations before becoming sufficiently controlled to work through their loss and grief. They will be on the lookout for casualties with specific and enduring symptomatology who require more intensive therapeutic care, and will treat them accordingly.

In retrospect the helpers will find the work professionally challenging and worthwhile. Like the casualties, they will find themselves reflecting on the meaning of life and reordering their priorities for living. A number will broaden the catechism of the scientist-practitioner model they might faithfully have adopted in their training to include a humanistic component with which to appraise human behaviour - their own as well as that of their patients and their clients. Despite the plaintiff cries of their logical positivist teachers, they might try to make up for lost time

by reading moral philosophy and comparative religion, the more comprehensively to understand the variety of inspirations, motivations, and value systems presented by traumatised people. As a result they would become better clinicians and wiser people.

At a more pragmatic level, the American Red Cross is to the fore with services to the public-at-large. It provides 10 hour training schemes for all its volunteers, no matter what their professional discipline. Other organizations such as the Critical Incident Stress Management group and the Green Cross respond in connection with employee assistance programmes. The latter provides a comprehensive three-tiered training service for its staff that entails progressive coursework and supervised practice. The first tier teaches the elements of immediate support leading to certification as a Field Traumatologist. The second offers more skilled intervention leading to recognition as a Certified (Clinical) Traumatologist, and the third gives project supervision and staff training leading to the title of a fully-fledged Master Traumatologist.

The content of the separate ARC, CISM, and Green Cross training courses have much in common. For example they all:

1. focus on the clinical signs and symptoms of acute and chronic trauma while being aware of those of other psychiatric disorders
2. differentiate between reactions attributable more to recent trauma than either to unresolved psychiatric disorder or to normal grief
3. indicate the kind of support casualties might require at different stages of disaster recovery and makes clear where it should be provided
4. acknowledge the spiritual components of behaviour
5. outline procedures by which casualties might be induced to convert their raw sensations into manageable memories, and
6. require potential helpers to be sufficiently self-disciplined and responsive to organisational demands to work as required without embarrassment, stress, and fatigue.

If anything the courses might be light on the cross-cultural implications of trauma-work, on the needs of children and the elderly, on the classification of disasters and disaster casualties, and on the organisational aspects of disaster and recovery. But their designers seem to be open for including such topics in future work.

Without necessarily adopting the given designations, the question arises as to whether a similar model of graded expertise might be adopted in Australasia for professionals attending to the immediate mental health of casualties. If in the affirmative, consideration would need to be given to the organisational structure necessary to bring it into operation – there is already more than enough helpful material to hand from leading practitioners and reputable organisations to settle the content of course-work. The latest draft guidelines of the International Society for Traumatic Stress Studies (2002) touches on some of these points, but its emphasis is more on training for service abroad than for service at home. Perhaps this matter is something that the Australasian Society for Traumatic Stress Studies

might like to take up with related bodies. It remains for traumatologists to move ahead without being too ambitious in their endeavours.

Nothing has been said about setting aside time later on for addressing the causes of technological and human disasters, much less about trying to fathom the mythological attributions for natural disasters that lead the fundamentalist zealots to torment the survivors for their sinful behaviour. But health practitioners and social scientists cannot stand aside from the debate for long.

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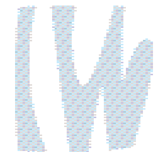

AFTER THE TSUNAMI: REFLECTIONS ON MY TIME IN SRI-LANKA

by Jennifer Dawson

The images that dominated our television screens in the immediate aftermath of the Boxing Day Tsunami revealed horrific destruction of property and massive loss of life. Yet even the graphic nature of the initial images did not prepare us for the extent of the tragedy unfolding across many Asian countries. With each passing day the death toll continued to climb to staggering figures and as more media landed in the affected countries the enormity of the disaster began to take on a sharper focus. This was a natural disaster of such destructive force that it had wiped out whole communities across the coastlines of many countries and as the waves receded it had left in its wake a ravaged landscape and nations of traumatised and grieving residents.

Just over a week into the above disaster I was asked would I travel to one of the affected countries, Sri Lanka, and repeat the trauma training I had offered in Africa last July to local workers attempting to deal with the aftermath of unfathomable war atrocities. My initial response when asked to similarly train local workers in Sri Lanka was to feel overwhelmed and inadequate for such a task particularly as this was a very different context to Africa. Sri Lanka was in the immediate aftermath of a natural disaster in contrast to the decades of ongoing human inflicted trauma of Africa (e.g., rape, mutilation, massacres) that I was more familiar with.

However, as the objectives of the training were clarified over succeeding days my sense of inadequacy switched to a sense of pride. I was proud that I had the opportunity to represent ASTSS and add to the financial gift given on our behalf by the Management Committee of ASTSS to the tsunami relief effort. I also felt somewhat privileged to have been given the opportunity to practically utilise my years of research into the impact of trauma on the mind and body. The following are just some brief details and personal reflections of my time in Sri Lanka which I hope will add to the images that bombarded your televisions over the Christmas/New Year period and give a brief insight into what life is like in Sri Lanka after the Tsunami.

Details of the Trip: I arrived in Colombo with three other team members at 12.30am on the 15th January surprised at how frantically busy the airport was at such a late hour, travelled to the outskirts of the city to an empty apartment (except for beds) and slept for a few hours before being woken at 5am by the sounds of the local temple calls to prayer. We then began three days of teaching to about 300 local workers (doctors, nurses, pastors, youth workers, social workers, helpers etc) eager to learn how they could manage their own trauma symptoms and those they sought to help.

The content of the teaching essentially followed the guidelines set out by the ISTSS in *Clinical and Community Settings Psychiatry 65 (2) 2002* for trauma training in community settings but structured around my PhD research on trauma and recent collaborative work between myself and Peter Blake (a child psychoanalyst who trained at Tavistock) on how to safely manage trauma in children. The teaching was translated into the native dialect of Tamil and Singulese and as I got to know the translators better there was often a lot of humour around whether what was

said was actually what was relayed. The feedback forms were extremely positive and I sometimes wonder if it was the actual trauma training or the unknown content of the interpreters that received such glowing praises.

After three fairly hectic days in Colombo the team then split and two team members travelled north to Jaffna and another Clinical psychologist and myself travelled to Batticaloa on the east coast of Sri Lanka with our interpreter, Anbahan, to repeat the three training days. If you have a look on a map of Sri Lanka the distance is not that great from Colombo to Batticaloa but due to damaged roads and bridges that had been destroyed by the Tsunami, the trip took nine rather bumpy hours. We arrived at around 5.30am, slept for an hour and then prepared to teach the 80 to 100 people who had registered. However, when Cliff and I arrived we were informed that word had spread from Colombo and several hundred people had turned up.
Batticaloa had been directly hit by the Tsunami and here Cliff and I spent three full days teaching, two late afternoons visiting some affected areas and the late evenings alone silently processing the many stories we had heard and the destruction we had seen. *(I still struggle to find words to express the impact of what I saw and heard and perhaps this article is my way of starting to attach words to the experience).* We then travelled another bumpy nine hours across the country (with a couple of adventures or rather misadventures on the way) back to Colombo to catch a few hours sleep before our midnight flight home. I returned to university the following day to resume writing up my research feeling somewhat more motivated that the years of hard work, financial cost and emotional drain on my family had been worth it.

What I saw:

* Scenes of such destruction that it was hard to believe that water had been the cause and not a nuclear bomb.
* Wells that were made of 3-inch thick concrete that had once been sunk 15 feet into the ground tossed across the landscape as if they had been made of paper.
* People's household and personal belongings strewn everywhere around and above in the tall palm trees.
* An open sandy space where previously a school had been (123 children had been in the school on Sunday and all had perished).
* Packs of dogs circling piles of rubble searching for bodies or body parts to fight over.
* Individuals combing the landscape for any remnant of loved ones - one man had only a portion of his wife's sari and a few of his children's school books after three weeks of endless combing for his wife and six children.
* Broken fishing boats 4 kilometres inland.
* Rows and rows of fresh sandy graves.
* Churches where people had been saved because they had been on higher ground and churches where some people had lost their lives.
* Optimism in many of the Sri Lankan people despite their deep grief.
* Selfless service by many of the Sri Lankan people for their affected countrymen. Many had worked day and night since Boxing Day cooking large vats of food and driving them daily across country to Tsunami hit regions.
* Evidence of aid getting through e.g., displacement camps full of tents, fresh water tanks at regular intervals across the country, food trucks, foreign engineers.

What I heard:

* I heard stories of miraculous escapes. For example, a healthy infant found caught in a fishing net on top of a Palm tree in Batticaloa two days after the

Tsunami had struck. A first hand experience by a passenger on a bus who survived water and black mud up to their neck. The bus had rushed to the beach after the first wave had hit, loaded it full of injured people and then got caught by the second wave – all survived.

* Graphic personal accounts of survival. One young woman described in detail how she had travelled to Batticaloa to spend Christmas with her elderly parents. They had gone to church (and were safe) and she had stayed home to clean the house for her mother. Without warning she found herself out side of her house being thrown against concrete walls and fences by a wall of water.
  Her description of how she survived was intense and graphic. She then described how she walked up the road to higher ground with water up to her armpits feeling the road with a stick so as not to fall into a well and just as I thought her ordeal was over she went on to describe an even worse experience as an even bigger second wave tossed her around the landscape like a piece of rubbish. For this young woman however, it is not her own struggle for life that continues to haunt her but the screams of an older woman that had been clinging to a tree near by. The screams of "why won't anyone come and help me" before she disappeared in the torrent of water continues to resound in this young woman's head in both her waking and sleeping states.
* Heartbreaking decisions made by parents who had to choose to let go of a child in order to save themselves and other children.
* Stories of bravery and courage of individuals who worked tirelessly to save many others in the immediate aftermath of the tsunami and subsequent days.
* Reports of difficulty sleeping and vigilance since the Tsunami by almost all participants attending the training (approx 600 people).

What I felt:

* Deeply saddened that after several decades of man made disaster – a civil war that had already killed so many Sri Lankan people and destroyed so much infrastructure – that Sri Lanka had now lost even more lives and been further destroyed by a natural disaster. Many workers I met described already traumatised communities now further traumatised by the Tsunami.
* Stunned by the destruction
* Inspired by the strength and optimism of the Sri Lankan people who have overcome so much adversity in their history and are determined to do so again.
* Deeply touched by the overwhelming gratitude of the participants and the organisers for the training offered.
* Blessed by the gift that the Sri Lankan people unknowingly imparted to me in return for my services – validation that many years of studying, working and researching trauma in addition to being a housewife and mother had indeed had an outcome worthy of the cost. For this I am deeply indebted to the Sri Lankan people who so graciously allowed foreigners to come in and share with them in their time of need.

Overall, I think what impacted me the most about my time in Sri Lanka was the realisation that trauma impacts people the same the world over. The people I met in Sri Lanka were similar to trauma survivors I have worked with in Africa and in Australia – no matter what the nationality trauma will break us all but some become stronger because of it.

"The world breaks everyone, then some become strong at the breaks"

Ernest Hemingway

JOURNALISM AND DISASTER

by Cait McMahon

In the Spring 2004 edition of Stress Points there was an article on the Dart Centre Australasia's launch and symposium in September 2004. This symposium was run with the support of the Victorian chapter of ASTSS. However, unfortunately the article did not actually explain what Dart was! Hopefully this will serve that purpose.

The 'Dart Centre for Journalism and Trauma - Australasia' is part of a global network of journalists, journalism educators and health professionals dedicated to improving responsible media coverage of trauma, conflict and tragedy. The Centre also addresses the consequences of such coverage for those working in journalism. Stories of trauma and violence are the stuff of news. Along with firefighters, police and emergency workers, journalists witness profound human suffering in their work. With other first responders, journalists face the dual challenge of responding professionally to what they witness and dealing with the psychological impact on themselves and their colleagues.

To these ends, the Dart Centre:

— Advocates ethical and thorough reporting of trauma; sensitive, professional treatment of victims and survivors by journalists, and greater awareness by media organisations of the impact of trauma coverage on both news professionals and news consumers.

— Educates working journalists about the science and psychology of trauma and the implications for news coverage through its website, academic research, seminars, workshops and training.

— Serves as a forum for print, broadcast and Internet journalists to analyze issues, exchange ideas and advance strategies related to reporting on violence and catastrophic stress. We also create and sustain partnerships among media professionals, therapists and others concerned with trauma, and nurture peer-support among working journalists.

During the tragedy of the recent tsunami the Dart Centre Australasia has been responsible for writing educational material for journalists, editors, managers and families of journalists on self-care, care of others, interviewing techniques of traumatized persons and the impact of stress and trauma from a psychological perspective. There has also been activity to assist with material aid such as sending cameras to photographers in Banda Aceh.

Reporting on natural disasters

One well known TV reporter told us that covering the tsunami was different than covering a man-made disaster such as a bombing or war. "Even though the devastation is significant it is somehow easier to accept because it has been caused by nature rather than man's inhumanity to man". On the other hand, another international reporter told us that she had reported on Banda Aceh for years in regard to their political struggle. She knew many people there personally and had spent considerable time there. She was then sent back to cover the tsunami. She commented that the "socio / political environment had

been cruel to the Achenese and now so was nature". It would seem that for the journalist, whether they are reporting on natural or human created disaster, the response will be as individual as the person covering it. What preliminary research does show on journalists and trauma is that mass casualties, of any kind, and the death of children seem to be consistently the most traumatic events for journalists to cover.

Joe Hight is on the executive committee of the Dart Centre in the USA. Joe is the managing editor of The Oklahoman newspaper. Following the hurricanes in Oklahoma in 1999 Joe encouraged particular practices within his newspaper, which the Dart Centre would hope other news media organisations emulate.

> » Victims should be approached but allowed to say no. If the answer is no, the reporter should leave a card or number so victims can call back later.
>
> » Little things count. Call victims back to verify facts and quotes. Return photos (if possible, hire runners to get and return photos). Emphasize writing "Profiles of Life" about the victims, instead of the usual stories about how they died.
>
> » Try calling funeral homes or representatives first to connect with a family member. In most cases, victims' relatives wanted to talk when they realized that the reporter was writing a "Profile of Life." Some of these led to bigger stories, too. Establish policies that affect your coverage.
>
> » Cover public memorial services for the victims rather than private funerals.
>
> » Find ways people are helping and report on them throughout the recovery process. (This provides hope for the community). That coverage must begin to focus on other parts of the community at some point. How much coverage is too much? When does the journalist become infatuated with a story when the public is not? A community is much more than a mass killing or disaster. Your newspaper or medium must reflect that.

So within the journalistic fraternity there is change afoot in regards to how the news media cover disaster. It is slow and embryonic, but it is happening. Journalists are becoming more aware of the impact of trauma on themselves and the victims / survivors whom they interview. It is hoped that this in turn will eventually create a change in the way that disaster and tragedy is reported overall. That eventually we will see more sensitive and respectful reporting and that news media professionals will adhere to the principle of "do no further harm".

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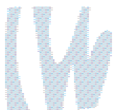

TURBULENCE FROM THE TSUNAMI

by Rob Gordon

The tsunami reverberated as a wave of arousal through our communities, including professional communities. A personal or social system is aroused by threat to its existence or by excitement of fundamental existential functions. A volunteer who worked in the Tsunami aftermath said it was the most important thing of his life, yet described a career full of value. He did little different there from what he might have done here. But the individuals he helped represented a group of sufferers who took the world's attention. The arousal was reflected in the media, donated goods that burdened damaged infrastructures, financial gifts and thousands of people wanting to help. Many others continued their lives with an altered sense of importance and perhaps guilt at their good fortune.

Arousal activates whatever is connected to its source. In individuals, it activates instinctual behaviours embedded in the psyche, materialised in subcortical centres. Their survival value is uncertain in the moment; some people are distressed they did not do the rational thing in traumatic a event; others cannot understand how they performed the right action. In a trained person, arousal activates pre-established functions, initiating purposeful action. In social systems, planning and training cause arousal to activate response patterns, whereas unprepared systems are thrown into confusion, improvising responses often against equally aroused misguided and counterproductive efforts. Disaster reports are full of instances where individuals and groups interfere, disrupt or prevent appropriate actions. This continues while arousal persists - which is until recovery becomes routinised. It may be reactivated any time (as can be seen in the court activity around the ACT fire inquest). Nothing guarantees arousal will lead to constructive results except knowledge and training.

Arousal enters professions. We feel tragedy, but also excitement, enhanced value in our work, projecting our region before the world. The suffering ignites our imagination through the abundant encounters we have of suffering in our clients' lives. It activates the desire that led us into the profession with the intensity of a communal catastrophe. We imagine what the disaster means to those affected and want to prevent or ameliorate it, which is our day by day practice. But are we and the profession able to transfer arousal into productive work? Thousands volunteered in many professions, often willing to pay their own travel. Some dropped everything and went.

However, the communities are disrupted; normal systems are missing that mediate between distressed people and service providers (Gordon, 2004a). Communal impact means even needed services probably will not reach their targets until social infrastructure is re-established, which can only be done by the local community and authorities in the context of their history and culture. Outside helpers need housing, food, transport and coordination, all already lacking for the community. The repeated selective reporting of tragedy and destruction from most media amplify arousal, and little coverage of recovery efforts prevents us imagining what is actually needed or the burden of our urge to volunteer.

Australians survivors arouse us to help. In disasters, all sorts of assistance is offered, from aroma therapy to free counselling, usually by people without direct contact with casualties. Their arousal breaks normal social and professional boundaries to find discharge. But it further dramatises the situation and pushes it outside normal help-seeking processes. Many survivors do not feel they need professional help, are threatened by the idea of it and confused by the erosion of normal support mechanisms.

Such 'convergence' contributes to 'the second disaster' of social disruption during recovery. However, those who have survived devastating experiences should be helped; though what do they need and how should it be provided?

The tide of arousal overlooks the small group of professionals in each state who busy themselves with these matters between events, observing and thinking about what is needed. Much is learned responding to regular small tragedies. In big events, their normal activities are aroused to activate knowledge and procedures prepared and trained for. However, each event is systemically different from previous situations so arrangements must be carefully adapted. Whenever previous lessons are simply rolled out for the next one, unique differences are not recognised; something is lost and some people miss out on what they need. The actuality of the situation and the assistance program have to be thought out every time.

Awareness in the community and professions have developed with September 11, Bali and the Tsunami. But awareness is not knowledge; a system is needed to communicate knowledge and values for recovery to those affected. It is heartening to see ASTSS and some professional organisations have entered this discussion thoughtfully and responsibly. However, there are not yet arrangements enabling the experience and expertise in the professional community to be constructively engaged with affected communities.

This knowledge includes various services needed throughout recovery, flexible coordination of government, non-government and private providers enabling those affected to choose forms and sources of assistance they want, policies incorporating knowledge and practices need to bridge the gap between normal health and welfare services and affected people in the aftermath. Such a system contributes to a social infrastructure for recovery and absorbs professional arousal in useful activity, while not losing site of important normal services and activities.

The survival-enhancing function of arousal has several predictable effects. It narrows attention onto threat at the expense of context and non-threatening information. Cognitive function is shifted from abstract, reflective, propositional thought to concrete, linear, immediate problem solving, enhancing the ability to resolve immediate threats at the expense of longer term, systemic implications. It promotes primitive unitary affects (fear, anger, sympathy, grief) at the expense of complex, socially constructed emotions (regret, remorse, empathy, disappointment). Aroused people become ego-centric to ensure their survival (and those important to them) at the expense of appreciating the point of view and effects on others (especially if not within their environment). We aroused professionals develop a narrowed appreciation of what is needed, formulate concrete strategies addressing immediate issues at the expense of the longer term and advocate for our own skills at the expense of others' roles or even the needs of affected people themselves.

Research indicates about 10-20% of

affected people sustain PTSD after disasters; bombings elevate it a further 15% and another 10% suffering from depression, anxiety and substance abuse (Gordon, 2003). Some 80% recover without extensive intervention. But there are adverse consequences degrading the quality of life of many without causing mental health conditions (eg., Kaniasti and Norris, 1999). Group, social and educational interventions are becoming recognised as the first line of intervention (WHO, 2003; van Ommern, Saxena and Saraceno, 2005) with the assumption that most of those affected recover without needing extensive clinical intervention (National Institute of Mental Health, 2002) and the importance of working through primary care practitioners (Molica, Cardozo, Osofsky, Raphael, Ager and Salama, 2004). Recovery occurs within effective social support systems; isolated people are more likely to need professional help. Recovery processes need to be understood and they can be supported prior to clinical intervention.

Those in clinical care often show why they did not recover. The intensity of horror conveyed by unpredictable and idiosyncratic sensory details may prevent integration. Preparing for death or loss that does not eventuate is dislocating (Gordon, 2005). Previous trauma or mental health problems may have absorbed their resources. Stress, despondency or exhaustion prevent them accepting the experience and they become depressed. Failure to terminate the sense of threat or initiate recovery by not receiving support maintains arousal and the trauma persists. The interpersonal network may be inadequate to recovery and neglect, reject or hurt them. Supporters may judge and criticise them from lack of understanding about trauma and recovery.

Adverse social processes reflect the fact ordinary people's assumptions about mental life are uninformed about trauma. The intensity of reactions disturb and frighten everyone and they fall back on commonsense 'folk psychology' – the psychological theory of naïve people about each others' mental life (Davies and Stone, 1995). They are unaware that after a disaster it is obsolete.

'Subclinical,' socially delivered mental health resources inform folk psychology and address debilitating responses that impair recovery or lead to clinical conditions; social interventions assist people to undertake their own recovery. A 'recovery community' with understanding of symptoms, vulnerabilities and resources constitutes a facilitating infrastructure into which information, education advice, opportunities for support and interaction can be provided (Gordon, 2004b).

Normal psychosocial recovery processes may be as incomplete and faulty as recovery from a physical trauma, which usually leaves some residual loss of function without careful medical support. If we understand recovery it is possible to enhance it. Some essential components are: clarity about the experience; confidence to deal with it; a frame of reference to give it meaning; continuity of care and social values following impact; availability of a supportive personal network; availability of a supportive community; capacity to make decisions and deal with problems.

But mere availability of others in social interaction without cognitive work may not enhance recovery even if defined as support. Repetitive, passive expression of distress aggravates depressive reactions. Specific processes are needed involving cognition rather that simple emotional expression. Sharing as such does not seem to make the difference, it needs constructive communication involving clarifying, organizing, translating the experience into language and creating meaning for it. Ruminative communication may intensify reactions by enhancing depressive thinking,

inhibiting motivation and problem solving, even reducing social support by being a burden. Involuntary avoidance and disconnection (repression) of experiences is associated with persisting depression; it increases sensitivity and distress when they intrude, preventing cognitive work and resulting in numbing and dissociation.

Supportive social interaction involves effective communication including positive affects (smiling, laughter, appreciation) related to constructive cognitive activity such as finding meaning and problem solving. It includes voluntary discrimination about what and when experiences are communicated or thought about. Conscious suppression or cognitive control limits the pervasiveness of distress, allowing other experiences to complement it, enhancing emotional control and regulation (Stroebe and Schut, 2001).

The helping professions are an essential part of recovery communities, as a body representing knowledge that enables directly and indirectly affected people to enhance their folk psychology and meet recovery demands. Large numbers of highly aroused "trauma counsellors," poorly integrated into the social system, pursuing their own professional folk psychology of therapy, encouraging emotional expression are a liability for people whose world has just been shattered (NIMH, 2002). Those who do not get hold of any victims to help remain aroused and become distressed, rivalrous or engage in conflict.

Arousal ignites whatever emotions, fantasies, attitudes, routines, stereotypes, behaviours and cultural practices it comes in contact with and they are unlikely to assist the complex, unpredictable psychosocial consequences of disaster and recovery. In the end, only knowledge performed in training contains arousal and ensures that it activates helpful activity (perhaps to do simple things or even nothing) and knowledge embodied in social and professional systems directs knowledge into the community's collective understanding to enable it to be the ever-present and lasting recovery resource available to everyone.

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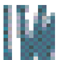

NEW SOUTH WALES

The next meeting is 7pm March 28, at 6/201 New South Head Rd, Edgecliff. 0414-710-101 At the last meeting, Dec 7, 2004, three members were present: Peggy Lee, Jen Davis and Beth Stone. Apologies from Jennifer Suneson.

The main topic was the possibility of a mini conference in November. The topics suggested were: Cultural issues and differences in Trauma Reactions and Treatment; Spirituality in Trauma Treatment; Life threatening disease as Trauma; and Nonverbal and Expressive methods of treatment. Which interests you? Or is there something else you burn to suggest?

We hope more people will come in March or voice an opinion by email

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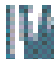

VICTORIA

This year has got off to a slow start and the Victoria Chapter Committee is in the midst of making plans for the year ahead. Just to let you in on our thoughts, we are considering combining the AGM with our Annual Dinner and propose that the AGM take place earlier in the evening followed by the dinner with a speaker yet to be selected. We would like to offer you this opportunity of meeting up with members and encourage you to come along to both. Non-members are welcome.

We are pleased with the response to our new practice of emailing Vic. members and will now continue to make contact in this way. ASTSS members were well represented at two recent forums we notified members about; the DHS Professional Development Forum and the Dart Centre for Journalism and Trauma which featured speakers who had worked in Asia following the tsunami.

Education Programme: Study/Discussion Group: Planning for this is in progress and confirmation of details will be available in the near future. We are planning to have a continuous 'open door' group meeting possibly on a monthly basis; reading texts will be set in advance and listed on the web site or by email. Discussion and visual aids will be focused towards assisting with familiarisation and memorising of terminology and increasing confidence with understanding how brain functions may respond to differing types of traumatic experience. This group will be at an introductory level but we would be very interested to hear from members who have expertise in neuro-psychology and who may like to offer their time and knowledge from time to time.

May 2005: Joint ACISA, ASTSS, CISMFA Symposium in May 2005: Posing a hypothetical scenario of a Chemical Biological Disaster in the city of Melbourne. Speakers will focus on the various needs of the public, emergency workers, professional community and how these may best be addressed.

We will inform you of upcoming events by email, also on the Victoria Chapter website. We would also like to have your ideas about further social and educational events and look forward to meeting up with you during the year.

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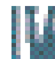


WESTERN VICTORIA

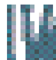
At our last executive meeting on February 18, 2005, discussion began surrounding the forthcoming conference in Ballarat in 2007. It could only be described as enthusiastic and realistic. Ideas were canvassed as regards venue, location, budget and possible speakers from local and Victorian agencies, and professionals both interstate and overseas. A recent APS conference in Ballarat was successful.

We discussed prominent trauma themes running through our local community. It is our intention to hold some seminars and a workshop leading up to our annual general meeting in October this year. Our next meeting on April 1 will finalize details of our program for the year.

We also discussed possible representation in Perth in September for the 2005 conference. One of our members, Caroline Taylor, has already been approached to speak at the conference.

While members have been engaged in holiday mode over the Christmas break, we were also called on in our individual professional and community service areas to respond to the Tsumani disaster, and its repercussions for families in our community.

There was also discussion on the status of training for emergency response teams.



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WESTERN AUSTRALIA

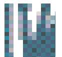
In Western Australia the general topics of disaster management and child abuse are always in the media.

Tsunami reached Western Australia, fortunately without any disastrous results. Increased waves were felt right down the west coast. Fishing boats were damaged in the harbour at Geraldton and in Geographe Bay, which is approximately three hours drive south of Perth. Three people were washed out to sea by a king wave produced by Tsunami. Fortunately a very strong swimmer and a kite surfer rescued them. A father and two little boys were brought safely to shore despite being very distressed.

Subsequently we have noted the terrible lethal bushfires in South Australia. Recently around Perth there have been many bushfires, which were deliberately lit, resulting in loss of property, flora and fauna. Fortunately there was no loss of life. The early afternoon sun was orange, covered with a haze. For several days afterwards the streets were filled with a smoky fog and a smell of burning eucalyptus. All of this makes us very aware of how vulnerable we are.

The WA Chapter is considering a disaster management plan providing training and organisation for an early response team and specialist referrals. This initiative is in its infancy but nevertheless will be addressed at our first clinical forum for the year.

In the headlines in our local newspaper it was noted that the coalition has made a statement on child abuse. The opposition leader, Colin Barnett, has pledged that they would introduce an enforced mandatory reporting of child abuse or neglect. It was stated that this was the first truly controversial policy announcement of the State election campaign. We have an election this month. All of this was part of a wider policy release dubbed, "Children, protection of our future and pitching the intention that the party would be a family friendly party." We are hoping that those in power will listen to what ASTSS has to say about child abuse and the long term cost to everyone in the community when we host the 12th Annual Conference on the theme of child abuse.



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TRAUMA CLASSICS: JUDITH HERMAN'S TRAUMA AND RECOVERY (1992)

by Andrew Moskowitz

In many ways, Judith Herman's 'Trauma and Recovery' is a most appropriate ending to the 'Trauma Classics' column (or at least, to my contribution to it). Published in 1992, it is the first book reviewed in this column that was written subsequent to the creation of the PTSD diagnostic category, and the first by a woman. As such, traumas suffered by women and children are appropriately emphasised, providing a balance to the previous books' emphasis on war trauma. It also offers a trenchant criticism of the PTSD concept – which remains central to the field of traumatology – that PTSD only makes sense in reference to acute, and not chronic, traumas. Herman calls for the establishment of a new diagnosis, which she refers to as complex PTSD, to address the psychological consequences of chronic trauma.

This is a wonderful book. There is no more appropriate way to start a review than to acknowledge that. 'Trauma and recovery' succeeds on so many levels that its status as a 'classic' is absolutely assured; indeed, one could argue that it is the one indispensable trauma 'classic' anyone working in the trauma field should possess.

While I will move through the details of Herman's text, I would like to start with the more formal aspects of this book. For starters, it is elegantly and organically constructed, with an inner logic that can legitimately be compared to a sonata or a symphony. This goes from the title on down. Each chapter makes perfect sense in the overall structure of the book, so that one can admire it, literally, as a work of art. This is what I was most surprised at in re-reading "Trauma and Recovery" for perhaps the third time. The book is also beautifully written, and targeted successfully to both professional and lay audiences – an achievement no prior book in this series has managed. Herman's compassion, respect, and wisdom shine through on every page, so that one genuinely feels that one is in the presence of a true humanitarian. And yet, her ego is almost completely invisible throughout; it is the courage of every trauma survivor that she champions, insisting that it is they, and not the clinician (regardless of how skilled) who are the real heroes of these stories.

The book is entitled 'Trauma and Recovery', which defines its two parts. In the first, named 'Traumatic Disorders', Herman reviews the history of the study of psychological trauma, describes the psychological and social aftereffects of acute traumatic experiences, and – the main innovation of this part – discusses the differences between acute and chronic traumas and makes the case for a new diagnosis for the latter.

A closer analysis of the six chapters of Part One reveals how organically Herman has constructed this book. She starts with a masterful chapter on the history of the study of trauma, perhaps the best introduction to the field available. She has called it 'A Forgotten History' to emphasise the periodic amnesias the field goes through. The chapter moves through the 'heroic' age of the study of hysteria, with Charcot, Janet, and Freud, the lapse of interest in the early 1900s

and the periodic rediscovery of trauma through the major wars of the 20th century. The chapter ends with a discussion of the women's movement, which Herman clearly identifies as her inspiration and identification, which allowed the acknowledgment of the traumas of rape, domestic violence, and child abuse. While this is the only 'historical' chapter per se, the rest of the text, particularly Part 1, is liberally sprinkled with quotations and references from prior trauma researchers and clinicians, revealing Herman's thorough immersion in the field.

The next two chapters cover the symptoms associated with acute traumas, with the first, entitled, 'Terror', explicating the three symptom clusters of PTSD, and the second 'Disconnection', discussing the resulting social isolation and disturbances of self. Again, these are among the most literate and accessible descriptions of the core components of PTSD, and its associated features, that one can find, and would be eminently suitable as an introductory text on the disorder. (Interestingly, Herman subsumes the 'avoidance and numbing' symptoms under 'constriction', which makes perfect sense to me). Then, in the second half of part one, Herman moves into a detailed discussion of the impact of chronic, as opposed to acute, trauma. Her next chapter is called, 'Captivity', and introduces Herman's resolute social and political agenda – bringing to light the suffering of women and children and equating it with men's traumas. A sample of this, which also gives a flavour of Herman's elegant and unobtrusive style, can be seen in the first few paragraphs of this chapter:

> A single traumatic event can occur almost anywhere. Prolonged, repeated trauma, by contrast, occurs only in circumstances of captivity. When the victim is free to escape, she will not be abused a second time; repeated trauma occurs only when the victim is a prisoner, unable to flee, and under the control of the perpetrator. Such conditions obviously exist in prisons, concentration camps, and slave labor camps. These conditions may also exist in religious cults, in brothels and other institutions of organized sexual exploitation, and in families.
>
> Political captivity is generally recognized, whereas the domestic captivity of women and children is often unseen. A man's house is his castle; rarely is it understood that the same home may be a prison for women and children. In domestic captivity, physical barriers to escape are rare. In most homes, even the most oppressive, there are no bars on the windows, no barbed wire fences. Women and children are not ordinarily chained, though this occurs more often than one might think. The barriers to escape are generally invisible. They are nonetheless extremely powerful. Children are rendered captive by their condition of dependency. Women are rendered captive by economic, social, psychological, and legal subordination, as well as by physical force (p. 74).

In this chapter, Herman discusses the psychological impact of 'captivity', including the so-called 'Stockholm Syndrome', beautifully. Here is how she explains how one could become attached to one's abuser or perpetrator, a notion the public finds so difficult to accept:

> Once the perpetrator has succeeded in establishing day-to-day bodily control of the victim, he becomes a source not only of fear and humiliation but also of solace. The hope of a meal, a bath, a kind word, or some other ordinary creature comfort can become compelling to a person long enough deprived… The capricious granting of small indulgences undermines the psychological resistance of the victim far more effectively than unremitting deprivation and fear (p. 78).

This is followed by a chapter on child abuse, as another form of chronic trauma. Herman then introduces the concept of 'complex post traumatic stress disorder', which at the time was under consideration for inclusion in the DSM-III-R, under the category 'Disorders of Extreme Stress Not Otherwise Specified' (or DESNOS); of course, it has not appeared in either the DSM-III-R or the DSM-IV. Herman argues compellingly that persons undergoing chronic forms of trauma typically exhibit disturbances (or 'alterations') in at least six domains:

1. affect regulation (including self-injury and dysregulated anger or sexuality)
2. consciousness (disturbances of memory, dissociative experiences)
3. self-perception (including shame, helplessness, a sense of defilement)
4. the perception of the perpetrator (idealisation, fantasies of revenge)
5. relationships with others (lack of intimacy, distrust)
6. systems of meaning (loss of faith, sense of hopelessness and despair).

She suggests that those currently labelled (and stigmatised) as suffering from borderline personality disorder (as well as somatisation disorder and some forms of DID) would be better characterised as suffering from complex PTSD. It may well be resistance to this idea, more than any concern with the reliability of the diagnostic criteria per se, that has so far kept this diagnosis out of the DSMs.

Had this slim volume simply ended there, after 130 pages, it would already have made a major contribution to the trauma literature. However, it doesn't. In Part Two, called 'Stages of Recovery', Herman articulates, more clearly and succinctly than anyone has to this point, what trauma survivors must go through in order to recover. In the first chapter, entitled 'A Healing Relationship', she argues forcefully that healing must be grounded in relationships – both the therapeutic relationship and the individual's relationships with their friends and family, and often, with other trauma survivors.

> The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections. Recovery can only take place within the context of relationships; it cannot occur in isolation. In her renewed connections with other people, the survivor re-creates the psychological faculties that were damaged or deformed by the traumatic experience. These faculties include the basic capacities for trust, autonomy, initiative, competence, identity, and intimacy. Just as these capabilities are originally formed in relationships

with other people, they must be reformed in such relationships (p. 133)

This chapter provides useful guidelines for therapy with trauma survivors, discussing transference and counter-transference, the therapeutic contract, and the need for the therapist – as well as the client – to have an adequate support system.

The next three chapters proceed to outline Herman's three-stage approach to trauma treatment, which has now become well known: phase 1 – Safety, phase 2 – Remembrance and mourning, and phase 3 – Reconnection. Herman is quite clear that she did not invent the stage approach to trauma treatment, noting that clinicians dating back to Janet had emphasised the importance of an initial stabilisation phase before beginning to explore the trauma. Nonetheless, in recent times, her voice has been the clearest (except perhaps for James Chu) in arguing that trauma treatment should not begin until the client is ready for it, and that to do so would be unethical and could well lead to re-traumatisation. Her emphasis on safety – in the therapeutic relationship as well as in the client's wider life – includes an acknowledgment that the trauma survivor must first learn to feel safe in her body. As trauma frequently leads to a sense of dissociation or disconnection from one's body, Herman advocates a range of approaches (including self-defence techniques) to the survivor become re-grounded in their body.

The subsequent stages are so well known that there is no need to describe them in detail here; only two points will be highlighted. Herman strongly emphasises the importance of mourning – both for what was lost and for what was never possessed (i.e., a 'normal' childhood) – as central to the process of healing. Her emphasis here is stronger than that accorded by many other authors, but in my opinion is solidly based on clinical reality. Herman also discusses, in the 'reconnection' stage, the importance of a 'survivor mission'. That is, she believes that trauma survivors benefit from finding a way to make meaning out of their experiences, to transform their traumatic experiences by extracting from them something positive – such as by helping others who have been faced with similar experiences or by taking political action for a cause.

These chapters contain numerous salient clinical vignettes from Herman's practice and those of her Boston colleagues, as well as from published reports. These vignettes are very helpful in illustrating the stages, which Herman is careful to point out is just a schematic and should not be taken too literally. In the final chapter, entitled 'Commonality', Herman discusses the important role of groups in treatment, thereby linking the trauma survivor to others and to the wider community. She solidly places recovery from trauma, as she did for trauma itself in Part One, in the context of social and political institutions.

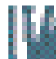
Ultimately, Herman's document is a hopeful one. The accounts of trauma survivors are often moving and frequently inspiring; their courage in facing adversity is striking. But what comes through most powerfully in the book is Herman's deeply compassionate and socially aware voice. Trauma and Recovery is by far the most popular book on trauma. For that, we should be glad, for the field of traumatology could have no more appropriate emissary than Judith Herman. If I have any criticism of the book (which is otherwise, essentially perfect) it is that Herman focuses on interpersonal traumas to the almost complete exclusion of environmental ones; it would be

good to see a book at some point– that takes as its primary focus natural disasters, and explores in detail the similarities and differences between responses to those and to the traumas caused by individuals. But that was not Herman's mission.

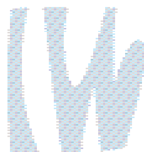
I would like to end this review with the final paragraph to the book, which could serve as a coda to the entire Trauma Classics series or as a goal for any trauma organisation. On a personal note, I would just like to say that I have appreciated the opportunity to review books for this series. I have learned a great deal along the way, and hope that you too have found the journey worthwhile.

> Commonality with other people carries with it all the meanings of the word *common*. It means belonging to a society, having a public role, being part of that which is universal. It means having a feeling of familiarity, of being known, of communion. It means taking part in the customary, the commonplace, the ordinary, and the everyday. It also carries with it a feeling of smallness, of insignificance, a sense that one's own troubles are "as a drop of rain in the sea." The survivor who has achieved commonality with others can rest from her labors. Her recovery is accomplished; all that remains before her is her life (pp. 235-236).

Andrew Moskowitz



Andrew Moskowitz has contributed all but three of the *Trauma Classics* over the last three years. It was Andrew's vision that regularly revisiting original texts would broaden our understanding and reawaken our curiousity. We thank Andrew for being so successful in his vision and so graceful and generous with his interpretations and reflections.



If you would like to contribute a *Trauma Classic* email the Editor at b.tarrant@latrobe.edu.au

12th Annual Conference Report

The Impact of Childhood Trauma Across the Lifespan: Historical Denial–Current Challenges

Perth 16–17 September 2005

Hi all, the Conference Committee has been kept busy bringing together a conference which promises to be dynamic and informative. Since the last report the Overseas Keynote Speakers have been confirmed, with Professor Onno van der Hart and Dr Marylene Cloitre addressing issues related to childhood trauma in adults and children respectively. Other confirmed speakers included Dr Carolyn Quadrio; Dr Ruth Wraith; Dr Brett McDermott; Professor Sandy McFarlane; and many more.

The diversity of the conference has attracted interest from a range of delegates from Mental Health professionals to Justice and Defence,and numerous organizations. By now hopefully everyone will have received the Preliminary Notice. If not, please check out the Conference website to download a copy or contact me via waconferenceorganiser@astss.org.au .

The Conference website is updated regularly with 'breaking news' and featuring photos from in and around Perth.

Due to the high level of interest we are now running a Post-conference workshop, with Dr Cloitre presenting a treatment approach for adult survivors of childhood trauma (9am-2.30pm). This will be suitable for practitioners from all levels of prior experience. Professor van der Hart's pre-conference workshop is designed to be interactive and assumes some experience working with traumatized adults. Dr McDermott's pre-conference workshop will focus on a treatment approach for traumatized children and adolescents. Pre-conference workshops are to be run concurrently. Numbers at all workshops are limited therefore early registration is strongly advised.

This year the Conference Committee is offering a 'Web-Hot Registration Special' with heavily discounted registration fees for those registering for one pre- or post-conference workshop plus the full conference prior to April 30. The full conference includes the 16th-17th conference plus the Welcome Function. Full details will be available in the Registration Brochure and on the Conference website. This option is highly recommended!! The Registration Brochure will be available by early April and will include schedule of fees and Program overview.

In response to the recent Tsunami disaster, and the presence of many Speakers with experience from this disaster and other large scale disasters, a "Disasters Over the Last Decade" seminar will also be held immediately following the conference. This will be a full day event with a number of speakers and discussion groups. It is anticipated that the Convention will attract delegates from many Emergency, Defence, and Aid organizations, as well as practitioners working in the area of large scale trauma. Immediate and long term challenges and interventions will be discussed. Regrettably, this seminar is not available as part of the Web-Hot special.

With such a rich program running over four days we have not forgotten the Social requirements of the Conference. The Welcome function will be held following the pre-conference workshops on Thursday 15th September. An enjoyable Conference dinner is proposed with details to be released at a later date. Social tours will be available following the conference, and after the post-conference workshop. Evening tours will also be available. To provide a different perspective of Perth maybe an early morning bicycle ride to the Old Swan Brewery for breakfast before the start of another day's conferencing and watch some of your colleagues take a quick Parasailing trip on the Swan River would be in order. For those extending their stay in WA trips to the Southern or Northern regions can be organized. Check out the Contacts page on the Conference website.

Thanks to everyone who has sent in their Expression of Interest forms via the Conference website. Abstracts are still being accepted for presentations and Posters, though closing date is soon. We look forward to seeing you at the conference.

Elizabeth Sachse
Chair, ASTSS 12th Annual Conference