Stress Points

eJournal of the

Australasian Society for Traumatic Stress Studies

Spring 2012

STRESS POINTS is the official electronic journal of the Australasian Society for Traumatic Stress Studies (ASTSS)

Stress Points is a quarterly ejournal produced by the Australasian Society for Traumatic Stress Studies (ASTSS). It aims to report and examine current developments in research, theory, clinical practice, social policy and inquiry in the field of trauma and posttraumatic mental health. Stress Points endeavours to be a forum for the multi-disciplinary exchange of ideas on posttraumatic mental health, with contributions and dissemination beginning with ASTSS members. Members and non-members can make contributions in the form of feature articles, reviews, interviews, research reports, meta-analyses or opinion pieces – all with the primary focus of trauma.

All contributions must be consistent with the stated mission of ASTSS: (1) to advance knowledge about the nature and consequences of highly stressful events, (2) to foster the development of policy, programs and service initiatives which seek to prevent and/or minimise the unwanted consequences of such experiences, and (3) to promote high standards and ethical practices in the trauma field. Furthermore, Stress Points serves as a major vehicle towards the goals of ASTSS: (i) providing quality services to ASTSS members, (ii) encouraging networking and development of ASTSS within the Australasian region, (iii) promoting standards of excellence in trauma research and practice among members, (iv) pursuing dialogue and links within the international trauma community, (v) encouraging exploration of different paradigms in research and practice, (vi) exploring the role of prevention in traumatology, (vii) seeking to influence the way traumatology is addressed in public policy and the media, and (viii) pursuing a role within the non-professional community through consultation and education.

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FROM THE PRESIDENT

JUSTIN KENARDY

I am delighted to be the incoming President for ASTSS and look forward to a very exciting two years. I would like to acknowledge the fantastic job that Doug Brewer has done over the past two years as well as the extraordinary contribution of the Executive Board members and staff. It is clear that ASTSS would not have the excellent place it does without Doug and the Executive.

I would also like to welcome a new member onto the Executive, Dr Eva Alisic, from Monash University. I hope you will get to know her over the next two years. As a young researcher I believe that Eva will help the organisation to continue to connect with the next generation of members to help carry the organisation into the future.

For those of you who attended the bi-annual conference in Perth this year I am sure you will have left replete with new ideas and information, will have caught up with old friends and possibly made some new ones . The conference was an intense three days with content that I found challenging and uplifting. The three keynote speakers focussed our attention on issues of complexity, diversity and recovery, the theme of the conference. Douglas Zatzick presented new work on public health and stepped care models in disaster and trauma. Pat Dudgeon was the first keynote to focus on indigenous trauma, challenging us to consider issues of cultural competence. Michael Scheeringa presented groundbreaking work on intervention with very young children following disaster. There were many other great presentations throughout the conference so I want to sincerely thank all of those who took the time to come and share their work, especially the student presenters.

The conference was run in partnership with the Australia Centre for Posttraumatic Mental Health and Associate Professor Meaghan O'Donnell very ably chaired the Scientific Committee. I would like to express my gratitude to her and the other members of both the Scientific and Organising Committees for all their fantastic work.

The next conference is planned for 2014 in Melbourne, I hope to see you all there.

Justin Kenardy, PhD, FAPS
President ASTSS

Kenardy, J. (2012). From the president. *Stress Points, Spring,* 3.

EDITORIAL

BY: BRONWYN TARRANT

This issue of *Stress Points* began with a broader theme, encompassing armed services and emergency first responders. However as the submissions arrived, we became aware that *Stress Points Spring* 2012 would be dedicated to exploring the experience of war and its impact on service personnel and communities.

This edition delivers papers from Australia, Germany and the USA exploring: mild traumatic brain injury; partnerships to improve PTSD treatments for veterans; the impact of war of children and families; and, the fictionalising process of documenting war.

Then we feature three outstanding presentations exploring possible means to the end of war, by Nobel Peace Prize recipient Jody Williams, Nobel Peace Prize nominee Scilla Elworthy, and 'One Day of Peace' activist and film maker Jeremy Gilley. Their talks document a progress of thinking over the last half decade which promotes person and community centered actions to prevent violent conflict.

Furthermore, complementing this edition of *Stress Points*, are two podcasts. In the **December 2012 podcast** we speak with Professor Alexander McFarlane regarding recent research in the area of military, peacekeeping and veteran posttraumatic mental health. Along with being Professor of Psychiatry, Head of the University of Adelaide Centre for Traumatic Stress Studies, Robert Laufer Award recipient, and Group Captain in the RAAF specialist reserve, Professor McFarlane is an Officer of the Order of Australia - awarded in 2011 for services particularly to veterans' posttraumatic mental health. To listen to the podcast visit the podcast page in December - you must be a member to access the resource.

The **November 2012 podcast** streams John Huston's ground breaking 1946 film "Let there be light". This groundbreaking documentary film depicting posttraumatic stress disorder (shell shock) was contraversially censored from public screening for 34 years. Having the original working title, "The returning psychoneurotic", "Let there be light" has now been fully restored and made freely available for public viewing and download. To read more about the film click here, to watch the movie - click the movie still below (total viewing time = 58 minutes).

'Let there be light" (1946)
November 2012 vodcast

As much of our current posttraumatic mental knowledge owes its origins to the battlefield, so too this issue offers relevance to researchers and clinicians from the broad range of specialty interests, therapeutic approaches and clinical populations, and not limited to veterans or service personnel. Likewise, whilst the Israeli–Palestinian conflict continues to mount an increasing civilian death toll, and civil war remains a daily event in over 45 nations in the world today, the issue of posttraumatic mental health morbidity prevention and treatment is important to us all.

Bronwyn Tarrant
Editor

Mild Traumatic Brain Injury due to explosions: a brief overview of the mechanisms of injury and clinical considerations

By: Nick Ford & Jeffrey V Rosenfeld

Detonation of improvised explosive devices [IEDs] is a frequent cause of wounding of soldiers in Afghanistan. Any part of the body is vulnerable to blast and blast injury may cause brain injury of all grades of severity (Rosenfeld & Ford, 2010). This paper primarily describes the mental health, cognitive and neurological consequences resulting from closed mild traumatic brain injury or blast mTBI, which is due to exposure to the pressure wave arising from high explosive detonation. Misattribution of symptoms may lead to adverse outcomes for the patient and great expense for the systems supporting them. It is therefore important that mental health professionals who assess and treat returning veterans understand appreciate the effects of blast mTBI.

TBI is described as closed or penetrating; and graded according to its severity. Severity is usually graded according to the level of loss of consciousness and duration of impairment; assessed by the Glasgow Coma Scale [GCS] and the duration of post traumatic amnesia [PTA]. Using the GCS mild TBI is 13-15, moderate is -9-13 and severe 8 or less. Mild TBI [mTBI] presents with a GCS of 13 or above in the absence of skull fractures and imaging abnormalities using CT and MRI (von Holst & Cassidy, 2004), there is a trend to classify mTBI as greater than or equal to 14. In mTBI loss of consciousness is brief and if there is a post traumatic amnesia it is less than 24 hours (von Holst & Cassidy, 2004). Concussion is an alteration in consciousness caused by a head injury, and is graded from levels I-III, with level III representing any loss of consciousness (American Academy of Neurology, 1997).

In civilian practice the majority of closed TBI's are caused by motor vehicle accidents, falls and assaults. These types of injuries also occur in military personnel (Schneiderman, Braver, & Kang, 2008) but explosive blast has unique qualities which cause different patterns of brain injury and co morbidity (Magnuson, Leonessa, & Ling, 2012). The majority of TBI's sustained by Australian military personnel are mTBI.

Traumatic brain injury, of all grades of severity, is associated with mental health issues due to injury to the emotion processing areas of the brain, emotional reactions to the event causing the injury and to cognitive and other deficits arising from the injury(Chen, Johnston, Petrides, & Ptito, 2008; Jorge & Robinson, 2003) .

The use of IED's in the conflicts in Iraq and Afghanistan has stimulated research into the effects of explosive blast on the brain, in the absence of penetration of the skull (Rosenfeld and Ford, 2010, Magnuson et al., 2012). In the current conflict in Afghanistan, 231 ADF members have been wounded to August 2012, and thirty-eight killed in action, approximately 50% of these casualties have occurred following detonation of an IED (Department of Defence, 2012). Some of these injured soldiers will have sustained a mTBI and most will have experienced events causing emotional reaction of horror, disgust, helplessness and fear of death or serious injury.

Military History

It has been commonly believed that shell shock; a set of behaviours, following exposure to high explosives was determined in World War I to be a synonym for stress-related psychiatric disorders. It was understood in World War I (Mott, 1916), and observed in subsequent conflicts (Barrow, 1944) and research (C. Clemedson, 1956; C. J. Clemedson, 1956), that close proximity to a high explosive blast gave rise to brain injury, even death, in the absence of skull penetration or impact. In the dire fighting conditions of World War I and the uncertainty of the effects of the new weapons, many individuals not exposed to blast, in any significant way, developed behavioural conditions that mimicked more or less closely the effects of concussion; a form of epidemic hysteria with the secondary gain of removal from the battlefield. This eventually led to the banning of the term shell shock in order to retain manpower (Shephard, 2000).

Effects of IED explosion in the current conflicts

The diagnostic issues following exposure to IED explosion are no less significant today with compensation systems offering different entitlements for conditions deemed primarily psychological or physical; but also high rates of suicide reported in US veterans from Iraq and Afghanistan. (Ramchand et al., 2011) Suicide has been less in ADF personnel, but the risk of mental

health problems remains high.

Uncertainty about the effects of high explosive blast on the human brain, and how to help those affected, has been reflected in the controversy in the literature over how much of the effect is emotionally based (C. Hoge, 2008) and how much is due to structural brain injury (Rosenfeld & Ford, 2010). Statistics, generated from self report questionnaires and extrapolation (Tanelian, 2008) have likely overestimated the numbers Iraq veterans suffering from mTBI and the costs which have been generated. This uncertainty may amplify the fear in returning veterans as to what will happen to them, and makes IED explosions potentially a more potent weapon in promoting disability.

Mechanisms of brain injury from explosions and the blast pressure wave

Injuries arising from blasts are described as primary through to quaternary (DePalma, 2005). These being;

1. The effect of the blast pressure wave.
2. Penetrating trauma from fragments.
3. The direct concussive and contre-coup effects of collapsing structures and being thrown by the blast wind.
4. Injuries due to burns asphyxia and exposure to toxins.

In addition to effects on the brain other areas most notably the eyes, ears [temporary or permanent deafness], vestibular apparatus [dizziness, vertigo and balance disturbance] and skin [burns] are likely to be affected in blast mTBI, with more widespread injuries, including amputations in individuals close to the source of explosion (Magnuson, et al., 2012).

Explosives cause a high pressure wave to sweep across the immediate surroundings at around the speed of sound, the intensity of this blast wave declining as a function of distance to the third power from its source (DePalma, 2005; Elsayed, 1997). Modern enhanced explosives, with secondary detonation of disseminated explosives, may increase this distance. The blast wave will reflect off solid surfaces, and magnify in a complex manner (Elsayed, 1997). As the blast pressure wave transits the body, turbulence, or spalling, arises at sites of different tissue density. The brain has several areas of variable tissue density, the gray and white matter interface and the cerebral ventricles, where spalling might occur.

Animal research has demonstrated transcranial transmission of pressure waves, resulting in structural and ultra-structural damage to the brain (Cernak, 2001; Chavko, Koller, Prusaczyk, & McCarron, 2007; Kaur et al., 1995). Transmission of an intravascular pressure wave up the neck might also contribute (Cernak, 2001; Knudsen & Oen, 2003).

Using a silicon model it has been shown that a blast pressure wave of relatively modest intensity spreads through the facial and skull bones (Nyein et al., 2010). Although helmets provided some protection, it was not significant, although transmission is reduced by the addition of a face plate (Nyein, et al., 2010).

Neuroimaging studies have been performed of soldiers with blast mTBI, but it is important to consider the timing of the imaging following the injury and the populations examined, for example evacuated versus non-evacuated personnel; and the presence of other trauma. Computed tomography [CT] and magnetic resonance imaging [MRI] scanning tend not to show lesions in mTBI (Mac Donald et al., 2011; Magnuson, et al., 2012) but diffusion tensor imaging [DTI] in cases of blast mTBI shows in some individuals damage to white matter tracts (Mac Donald, et al., 2011) (Bazarian et al., 2012; Davenport, Lim, Armstrong, & Sponheim, 2012; Matthews et al., 2011; Morey et al., 2012; Warden et al., 2009). In some studies more than one mechanism of injury [pressure wave and direct impact] were found to have occurred (Mac Donald, et al., 2011). The cerebellum, pons and inferior surfaces of the frontal and temporal lobes may be affected (Peskind et al., 2011). Using quantitative electroencephalography [q EEG], a small study demonstrated reduced interhemispheric phase synchrony in the frontal areas (Sponheim et al., 2011). This was a different pattern to that seen in mood disorders and posttraumatic stress disorder [PTSD] in patients with blast mTBI (Sponheim, et al., 2011). The EEG changes correlated with decreased frontal white matter integrity seen on DTI (Sponheim, et al., 2011).

These areas are important in cognition, motor coordination and also emotion processing and damage to the latter functions might be expected to lead to higher rates of psychiatric illness (Davidson, 2002). There is some support for this. Blast mTBI is strongly associated with [PTSD] and depression (Sayer, 2012), and the degree of alteration of consciousness correlates with the development of psychopathology in blast mTBI (Hoge, 2008).

In athletes who have suffered a concussion the

intensity of depressive symptoms correlated with damage to medial frontal and temporal gray matter, and was independent of prior or family histories of depression (Chen, et al., 2008). There may also be a vulnerability window; recovery in athletes is significantly slower after a second concussion (Slobounov, Slobounov, Sebastianelli, Cao, & Newell, 2007). In sports related concussions there are adverse cumulative effects on intracortical inhibitory systems and visuo motor coordination (De Beaumont, Brisson, Lassonde, & Jolicoeur, 2007). The cumulative effect of multiple blast mTBI is at this stage unknown.

Assessment

Assessment of the types and degrees of disability in military personnel who have returned to Australia is best done by a multidisciplinary team comprising not only mental health professionals, but also neurosurgeons, neurologists, occupational therapists, rehabilitation specialists, neuro-ophthalmologists, ear, nose and throat [ENT] surgeons, physiotherapists including vestibular therapists and audiologists. Veterans who have experienced blast mTBI and have complaints such as dizziness, headaches and coordination problems should not have these symptoms ascribed to somatisation without consideration of possible physical causes.

The level of blast exposure

In considering the likelihood of mTBI, the GCS and the duration of loss of consciousness or altered awareness must be considered. The initial assessment is likely to have been performed by a medic, in a hostile environment, and data may be limited. However a Military Acute Concussion Evaluation [MACE] score is required to have been done at some point by a medic or medical officer. The MACE [Table 1] is an assessment of concussion devised in the US and incorporating historical data but also the standardised assessment of concussion [SACE], a validated cognitive assessment tool (Marion, Curley, Schwab, R Hicks, & Workshop, 2011). Further information regarding assessment protocols in theatre may be found from the Defence and Veterans Brain Injury Centre (DVBIC, 2009). Self reports of loss or diminution of consciousness can be quite inaccurate and relate not only to head injury, but also stress, fatigue and environmental factors (C. W. Hoge, Goldberg, & Castro, 2009). The likelihood of blast m TBI is amplified in confined compared to open environments.

Immediately after blast mTBI, there is likely to have been reported nausea and vomiting, headache, vertigo and unsteadiness, and cognitive defects leading to impaired performance (DVBIC, 2009) (Magnuson, et al., 2012). Due to recent increased awareness of mTBI in the ADF the TBI is likely to have been detected and documented. In some cases the initial injury will not have been reported to medical personnel, although the blast exposure will be documented in unit records. It should be remembered that the presence of neurological deficit, skull fracture or lesion visualised on imaging implies a more complex mTBI with a different prognosis to that of mTBI (Iverson, 2005).

At present there are no reliable biomarkers or agreement regarding assessment tools (Marion, et al., 2011). Neurofilament heavy chain protein has been suggested as one possible biomarker (Gyorgy et al., 2011). Blast dosimeters attached to helmets or clothing to show the actual blast pressure exposure encountered are used, noting the capricious nature of the blast pressure wave and its magnification by solid surfaces, these provide a real-time quantitation of exposure(Chu, Beckwith, Leonard, Paye, & Greenwald, 2012). This is important as blast wave reflection may cause some individuals to be unaffected while another quite close is rendered unconscious (Barrow, 1944; Cullis, 2001).

Visual, auditory and vestibular injuries

Military personnel tend to be highly athletic and require agility as essential for their work, but also a source of self-esteem. Following blast mTBI subtle disturbances of coordination leading to clumsiness, and balance disturbances and difficulties moving in darkness will lead to heightened anxiety and aggravate any existing anxiety or mood disorder. In blast mTBI the most common visual deficits are reduced stereoscopic vision, defective pursuit and saccadic eye movements, and decreased amplitude of accommodation (Capo-Aponte, Urosevich, Temme, Tarbett, & Sanghera, 2012). From a functional perspective there is likely to be reduced reading speed and comprehension, difficulties descending and climbing, and moving rapidly [running and driving] or moving in low light (Capo-Aponte, et al., 2012; Lew, Weihing, Myers, Pogoda, & Goodrich, 2010). Photosensitivity is common (Capo-Aponte, et al., 2012). In blast mTBI these symptoms may synergise with anxiety and depressive symptoms, as has been described with other traumatic injuries (R. A. Bryant et al., 2010).

Damage to the ears and vestibular system leading to hearing impairment, tinnitus and balance is

common following blast mTBI (Lew, et al., 2010; M. R. Scherer & Schubert, 2009). Patients report a variety of symptoms; subjective dizziness, balance problems, clumsiness and problems with complex rapid movements (M. Scherer, Burrows, Pinto, & Somrack, 2007). Assistance from an ENT surgeon and vestibular therapy is helpful (M. Scherer, et al., 2007).

Emotional disturbance

Differentiating between emotion-based and physically based syndromes arising in the context of mTBI is problematic (R. Bryant, 2011). The post concussion syndrome has substantial overlap with PTSD with overlapping symptoms of heightened startle, irritability, memory disturbance, impaired sleep, fatigue and depression (R. Bryant, 2011). Among blast mTBI patients the presence of exposure to high combat stress increases the likelihood of post concussive symptoms (Cooper et al., 2011). This might suggest that the post concussive symptoms are representative of only emotional disturbance; however there is a strong association between the extent of LOC and the likelihood of mood and anxiety symptoms (C. Hoge, 2008; Schneiderman, et al., 2008) suggesting that mTBI acts as a catalyst for the generation of emotional symptoms, which then lead to pervasive difficulties in adjusting to the post concussive state (Cooper, et al., 2011). In the post concussion syndrome headache and vertigo are also likely to be present, but distinguishing, for example, vertigo from dizziness due to panic can be challenging. The situation is even more likely to be complicated by both syndromes coexisting. In addition there may be difficulties in occupational adjustment and family adjustment as the veteran returns home, and wishes to retain their career in the ADF.

The link between suicide and traumatic brain injury in US veterans has been cited as significant with a 1.5 fold increase in risk (Berglass, 2011). Although careful analysis suggests that the link is mediated primarily by mood disorders and PTSD symptom severity (Barnes, Walter, & Chard, 2012; Skopp, Trofimovich, Grimes, Oetjen-Gerdes, & Gahm, 2012). It has not yet been clarified whether comorbid conditions, such as motor and cognitive problems, in blast mTBI aggravate the risk of PTSD and depression independently. An overall increase in suicide rates in US veterans; from 110 per 100,000 to 268 per 100,000 between 2001 and 2008 has been reported (Ramchand, et al., 2011) Important associations were mental health problems, marital breakdown, disciplinary issues, work stress, deployment, mental health visits and SSRI prescription (Hyman, Ireland, Frost, & Cottrell, 2012) . This underscores the importance of early psychiatric consultation and diagnosis in ADF personnel.

Cognitive functions

Assessment of cognitive functions in suspected blast mTBI should consider executive function, multi tasking, memory, concentration, information processing speed and the effects of fatigue. Computerised programs may better detect deficits as has been suggested in sports injuries (Coppel, 2011). Some programs are commercially available, such as CogState which is used to screen ADF personnel deployed to Afghanistan and appears to have good correlation with conventional neuropsychological testing (Maruff et al., 2009).

Neuropsychological assessment has suggested that blast injured patients are more likely to have cognitive impairment, similar in type to other patients with TBI (Belanger, Kretzmer, Yoash-Gantz, Pickett, & Tupler, 2009), and also a greater likelihood of psychological symptomatology (Sayer et al., 2008). Cognitive functions that are most affected in civilian mTBI are memory, complex attention [multi tasking] and executive function (Bogdanova & Verfaellie, 2012) and this association may pertain in blast mTBI.(Belanger, et al., 2009). Cognitive deficits are also known to occur in the affective and anxiety disorders and may, or may not, have a different prognosis from those occurring after blast mTBI (Baune et al., 2010; Beblo, Sinnamon, & Baune, 2011)(Wagner, Doering, Helmreich, Lieb, & Tadic, 2012). There are also neuropsychological effects of deployment. In US soldiers recently returned from Iraq, without psychiatric illness or exposure to blast, decreased concentration, increased reaction time and memory have been demonstrated and are believed to be related to exposure to the combat environment (Vasterling et al., 2006).

The effects of cognitive rehabilitation are unknown but there are strategies evolving which are beyond the scope of this article (Bogdanova & Verfaellie, 2012; Schultz, Cifu, McNamee, Nichols, & Carne, 2011).

Pain

Pain, psychiatric disturbance and TBI often occur together and have been described as the “Polytrauma Triad” (Lew et al., 2009). Medication effects, such as over or under use of analgesia

may be present, it has been noted that blast mTBI patients have high rates of analgesic consumption (Sayer, 2012). In the absence of other wounds and injuries the commonest form of pain in blast mTBI is headache, closely followed by musculoskeletal pain (Sayer et al., 2009).

Treatment Considerations

Psychotherapies are likely to need augmentation with psychotropic medication used judiciously to avoid adding sedation to the cognitive burden, although attention to sleep will be important. Psychological treatments may need modification to account for slowed information processing and memory deficits. It may also be the case that exposure based treatments are of less use than treatments directed toward emotion regulation such as mindfulness training.

It is important to consider the role of exercise, both aerobic and targeted to deficits in coordination and balance and to encourage some self-direction in implementation. The use of the term traumatic brain injury may be very challenging to patients and therefore unhelpful. It may limit efforts toward recovery and there will be implications for compensation. The more familiar term concussion may better enable expectations of recovery. Most, but not all, individuals with concussion will recover, from the concussion, in the first year (Iverson, 2005)

Analgesia should be used judiciously; and the causes of headache ascertained, where possible. Some patients may use opiates primarily for their mood enhancing and anxiolytic effects. Complex issues around illness behaviour, either illness affirming or illness denying, in the presence or absence of compensation entitlements may further complicate assessments.

Rest, particularly in the acute stage of recovery from blast mTBI, is important, but should not be allowed to become avoidance, which is common in PTSD and depression. If the veteran remains within the ADF there must be liaison with the base medical officer, and commanders to enable suitable, and a graduated level of complexity of duties. Veterans who are leaving the ADF are likely to encounter a rehabilitation provider, who will need advice on appropriate activities and benchmarks. The approach overall should be expectant toward improvement in functioning, and encourage a degree of self-direction and autonomy. The longer-term outcome of individuals affected by blast, mTBI, and their likely response to the usual evidence-based treatments remains unknown (Sayer, 2012; Sayer, et al., 2008). Anecdotal evidence suggests a considerable improvement in functioning can be achieved, although in severely affected individuals, as benchmarks and challenges arise, there is often a catastrophic reaction and there is a need to consolidate and if necessary re-evaluate timeframes and goals.

Conclusions

Blast induced mTBI, or blast concussion is frequent in personnel who have deployed to the MEAO and Afghanistan and overlaps with psychiatric illness to magnify disability due to subtle physical and cognitive impairment, neural compromise of structures that process information and exposure to traumatic environments. There is a clear need for objective data to verify that a TBI occurred; and to thoroughly assess deficits. The compensation environment may complicate the presentation. Frustrations at misdiagnosis may amplify anxiety and hinder adaptation. Management should be expectant, problem focussed, and compassionate. There remains much to be understood; timeframes of recovery and the impact of multiple blast exposure being two areas of interest.

The study of blast concussion illustrates the need to examine the past history of military psychiatry carefully (Rosenfeld & Ford, 2010). The notion that shell shock is purely an emotionally based condition is not supported by past research. It is a complex amalgam of physical and psychological disabilities requiring careful dissection of aetiologies and a problem oriented approach to treatment. As one veteran with blast mTBI observed: “I’ve seen oodles of dead bodies, and I don’t think this is PTSD; I get lost, I can’t run without tripping and I can’t remember things; I think I injured my brain.”

Disclaimer: These are the views of the authors and do not reflect ADF policy.

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A clinical and research partnership to promote effective PTSD treatment for veterans

By: Anne-Laurel Couineau, Delyth Lloyd, Des Perry, Katherine Hawkins and David Forbes

There is a strong evidence base for trauma-focussed interventions for the treatment of post-traumatic stress disorder (e.g., Bisson et al. 2007; Institute of Medicine [IOM], 2007). However, it is commonly acknowledged that these interventions are infrequently adopted by mental health practitioners. Only between 17 and 20% of practitioners deliver exposure-based treatment, even among those who specialise in treating veterans (Becker, Zayfert, & Anderson, 2004; Minnen, Hendriks & Olff, 2010; Rosen et al., 2004). This presents a two-fold challenge for the Australian clinical and research community: first, to ensure that evidence-based interventions are relevant in the context of a clinical service or a therapist's day to day practice, and second, to promote those interventions in a way that is meaningful and useful for practitioners. In other words, we need to identify interventions that are effective with the average mental health client, and within the day to day reality of a clinical service (e.g. waiting lists, staff with varying levels of qualifications). We also need to develop a science around the dissemination and implementation of best practice in order to identify strategies that will lead to the widespread and long-lasting uptake of effective therapeutic interventions.

It is particularly challenging to increase the adoption of evidence-based treatments in service systems that have a large and diverse group of providers and a client group with complex needs, such as the veteran population. The community-based Veterans and Veterans' Families Counselling Service (VVCS) is such a service, with offices in city-based and rural locations and with staff from a wide range of backgrounds and therapeutic orientations. In partnership with the Australian Centre for Posttraumatic Health (ACPMH), VVCS has engaged in research examining the effectiveness of an evidence-based treatment—Cognitive Processing Therapy—within their service system and has undertaken a systematic investigation of its implementation into day to day practice.

Effectiveness of Cognitive Processing Therapy in a real world setting

Cognitive Processing Therapy (CPT) is a manualised 12 session cognitive behavioural treatment for Posttraumatic Stress Disorder with a growing evidence-base, including in veteran and military populations (e.g. Monson et al., 2006). CPT is an alternative to traditional exposure treatment which involves cognitive therapy and a written exposure component. The treatment systematically addresses key posttraumatic themes including power and control, safety, self-esteem and intimacy. The effectiveness of CPT was examined through a randomised control trial that involved VVCS clinicians and veterans routinely seen by the service.

Clinicians included in the trial included social workers and psychologists with a range of therapeutic orientations (25% practiced Cognitive Behavioural Therapy (CBT), 50% had an eclectic practice and 25% explicitly did not use CBT). Veterans included in the trial accessed counselling through the service's usual intake and referrals routes. This study was the first Australian trial of CPT in a naturalistic community service setting and has made a world leading contribution to effectiveness research for posttraumatic stress disorder. The trial found that 67% of veterans receiving CPT demonstrated clinically significant improvements in PTSD over 3 months and significant improvements in anxiety, depression, social and partner relationships (Forbes, Lloyd et al., 2012). Critically, the intervention was acceptable to both clients and VVCS practitioners.

From examining effectiveness to understanding what facilitates best practice

While effectiveness trials such as the one described above are critical to ensuring that clinical services and practitioners have access to evidence that is relevant to their day-to-day practice, they do not guarantee that practitioners will use this evidence to inform their practice. Promoting the uptake of even simple clinical practices, such as mood monitoring, let alone complex ones, such as CPT, is difficult to achieve and is influenced by a range of barriers and facilitators (Grimshaw et al, 2006). Current implementation research emphasises the interaction between an individual's decision to adopt a recommended practice, the characteristics of the practice to be adopted and organisational factors (Greenhalgh et al., 2004). This research

underlines the importance of understanding individual and organisational readiness to change in order to promote the adoption of new evidence-based practices.

Given the complexity involved in promoting evidence-based interventions, VVCS and ACPMH conducted a study examining organisational and therapist factors likely to influence the uptake of trauma-focussed interventions, particularly imaginal exposure. These factors were used to tailor strategies aimed at increasing the uptake of trauma-focussed interventions at three VVCS pilot sites. The barrier identification process highlighted the importance of considering factors other than knowledge and skills when developing strategies to support the uptake of new treatments. While confidence in using imaginal exposure was a significant barrier to the use of trauma-focused interventions, expectations about treatment outcomes were also an important consideration for therapists when selecting a treatment option. Organisational factors such as client waiting lists, a perceived need for a PTSD specific policy, and group cohesion also had some impact on treatment choice. It was found that a training and implementation process tailored to organisational and individual barriers led to a significant increase in the use of imaginal exposure in the treatment plans of veterans assessed as having PTSD—from 45% to 80% six months following the implementation process (Couineau & Forbes, 2011).

Promoting CPT across a nation-wide service

Having established the effectiveness of CPT for treating veterans in the VVCS service system and having developed an understanding of service-specific barriers and facilitators of the adoption of trauma-focussed interventions, VVCS is now rolling out a national implementation strategy to promote the use of CPT amongst its workforce. The twelve month implementation process will involve tracking facilitators and barriers to the uptake of CPT and examining the efficacy of clinical and organisational implementation strategies tailored to those barriers.

To understand the CPT adoption process within VVCS, the trial examined factors such as individual motivation and beliefs about CPT, organisational resources and climate, as well as formal and informal leadership. The initial barrier and facilitator assessment indicated that organisational support for clinical practice, a strong clinical supervision culture and therapists' positive attitude towards CBT and manualised treatments were factors likely to facilitate the uptake of CPT. The initial assessment further indicated that implementation strategies needed to address therapists' confidence in using the intervention and fears about increasing client distress. The need to support collaborative treatment planning with clients and to encourage team cohesion and communication around implementation goals was also identified.

In order to address the above barriers, a range of clinical support strategies are in the process of being rolled out, including training, fortnightly peer meetings that include expert consultation over a six month period, and a "booster" workshop scheduled six months following the initial training. Organisational support strategies include training of clinical leaders, monthly leadership meetings and the integration of an intake procedure and outcome measurement in day to day procedures and IT systems.

During the first six months of the implementation, the skills development component (training and fortnightly expert consultations) was completed and 82 clients received CPT. The impact of the implementation process on barriers to the uptake of CPT, rate of use of CPT and client outcomes will be examined over the next six months.

Conclusion

Studies undertaken in partnership with community organisations which factor in the context in which an intervention is tested are a powerful vehicle for closing the gap between evidence generation and the realities of clinical practice (e.g. Glascow & Emmons, 2007; Proctor et al., 2009). The research conducted at VVCS is providing important information about the effectiveness of a new treatment for the Australian veteran and military populations and, more importantly, offers a model for conducting research embedded in clinical services. It also presents an approach that goes beyond assessing the effectiveness of a therapeutic intervention: it examines its applicability to day to day clinical practice and identifies resources required for successful implementation.

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War at Home - Consequences of War Trauma on Family Life

By: Claudia Catani

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

A cycle of violence in the context of war

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

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

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

War-torn families

The dramatic consequences of war and other forms of organized violence become particularly complex, when the entire family is affected or lives in a conflict zone. How does a child grow up, if not only is his father traumatized, but also his mother, his siblings, and, above all, he himself, are exposed to repeated traumas of wartime violence? Initial evidence comes from a study with more than 1,000 Palestinian adolescents indicating an increased rate of physical violence within the family (Haj-Yahia & Abdo-Kaloti, 2003). The strongest predictor for the amount of violence experienced by the adolescents at home was the number of political stressors to which the family was exposed to. Surveys with school-children in Afghanistan and Sri Lanka (Catani, Jacob, Schauer, Kohila, & Neuner, 2008; Catani et al., 2009) indicated that physical violence within the family was much higher than in politically stable Western countries. In both samples, the amount of war experiences reported

by the children resulted as a key predictor of family violence. These findings were confirmed by a longitudinal survey in two Kabul schools highlighting the importance of family violence over war-related as well as socio-economic stressors in predicting changes in mental health problems in Afghan children (Panter-Brick, Goodman, Tol, & Eggerman, 2011). Here, the authors concluded that "domestic violence is often a response to structural and collective violence" (Panter-Brick et al., 2011, p. 360). Taking these findings together, it seems that the specific interplay of stressors and traumas on various levels (individual, family, and community) appears to make families, and especially children, particularly vulnerable to the development of psychological disorders such as PTSD (Catani et al., 2010).

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

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The Killer Elite

Review By: Paul D. Carter

'The Killer Elite'
Evan Wright
Rolling Stone Magazine,
June 26, July 10 and Jul 24, 2003

Osama Bin Laden was assassinated in his residence in Abbotabad, Pakistan by US Special Forces on May 2, 2011. A $30 million movie version of these events, 'Zero Dark Thirty', is scheduled to be released on January 11, 2013. Its director is Kathryn Bigalow, whose 2008 account of an elite bomb squad unit in Iraq, 'The Hurt Locker', won Academy Awards for Best Original Screenplay, Director and Picture.

How Bigalow represents the hunt for Bin Laden and his assassination will doubtless be the subject of much controversy. The film's release so soon after the events it depicts, and the mythologising power of the Hollywood machine, raises uneasy questions about the ways we are able to understand war and the kinds of accounts that inevitably colonise our imaginings of it. Do these visceral, shaky-camera narratives enhance our understanding of what war is like or are they inescapably crass exploitations of war's cinematic potential? Do we have an ethical responsibility to the victims and survivors of warfare in the way we reconstruct their experiences?

What distinguishes many present war-filmmakers from their forebears throughout most of the twentieth century is their desire to provide viewers with a sense of in-the-moment authenticity. Bigalow and her contemporaries borrow the techniques of documentary filmmaking to give their work a greater sense of immediacy in the same way as newspaper and magazine journalists since the 1960s have borrowed techniques from fiction to do the same. Characters in these films exist in a world difficult to distinguish from reality, just as the real-life interviewees of journalism are now often presented as characters who speak in dialogue. Aesthetically speaking, in both mediums, fantasy has drawn closer to reality and reality to fantasy. "It was just like a movie," you might say of non-fiction story. "You feel like you're there," you might say of a film.

One of the more famous, and cinematic, recent non-fiction accounts of US soldiers' wartime experiences was provided by US journalist Evan Wright in his three-part series 'The Killer Elite', first published by 'Rolling Stone' magazine in June 2003 and a year later at book length as 'Generation Kill'. Wright went on to act as a consultant on the seven-part HBO television adaptation of his account. Its principal writers, David Simon and Ed Burns, had been previously celebrated for the sense of realism they brought to their hit fictional show 'The Wire'.

In March 2003, Wright spent two months embedded with a battalion of Marines as part of the first wave of US forces to invade Iraq. Though Wright wrote these pieces upon his return to US soil, each is narrated in the present tense, the tense of film. As Wright follows his battalion of 'ambush hunters' during their assault on Baghdad, he paragraphs action and dialogue according to fictional conventions, allowing the Marines' words to resonate thematically as he describes their exploits.

> We drive into a no-man's land. A burning fuel depot spews fire and smoke. Garbage is strewn on either side of the road as far as the eye can see. The convoy slows to a crawl, and the Humvee fills with a black cloud of flies.
>
> 'Now, this looks like Tijuana,' says Pearson.
>
> 'And this time I get to do what I've always wanted to do in T.J.,' Colbert answers. 'Burn it to the ground.'

Wright's battalion are killers: barbaric, adrenaline-addled 'devil dogs' (the US military's collective nickname for Marines) itching to 'get some' in the blood-rush of combat. Most are in their early to mid-twenties, some barely out of their teens, but all are 'physical prodigies who can run twelve miles loaded with 150-pound packs, then jump in the ocean and swim several more miles, still wearing their boots, fatigues and carrying their weapons on their backs'. It's hard not to see them as the cousins of the murderous regiment in Stanley Kubrick's 'Full Metal Jacket' who sing the 'Mickey Mouse' anthem as they march through

another decimated Vietnamese village.

Wright himself can't escape the influence of cinema upon his reconstruction of events. It makes his perceptions at times appear detached, as though he is experiencing them from the other side of a screen. "It looks like we've driven into a Vietnam War movie", he remarks when the battalion arrives at the bank of the Euphrates River. When under fire, he notes that "incoming rounds make a zinging sound, just like they do in Bugs Bunny cartoons". He describes Nasiriyah as 'one of those sprawling Third World mud-brick-and-cinder-block cities that probably looks pretty badly rubbled even on a good day' and the outskirts of Baghdad as 'the usual horrorscape of a country at war'. 'One of those'; 'the usual'; bear in mind that Wright's 'Rolling Stone' audience is mostly middle-class Westerners. What ideas of 'those' and 'the usual' does he think are so familiar to us that we can picture them for ourselves?

Despite this idiosyncrasy, Wright's skills as a non-fiction storyteller are first-class. He knows how to characterise members of the battalion through their dialogue alone, as in this exchange between a sergeant and corporal on their second night in Iraq:

> "Make sure you don't shoot the civilians. We are an invading army. We must be magnanimous".
>
> '"Magna-nous?" Garza asks. "What the fuck does that mean?"
>
> "Lofty and kinglike," Colbert answers.

When dialogue isn't available, his eye for physical details suggests with great power the cauterised sensibilities of the Marines as they deal daily with the probabilities of their own and their friend's deaths. On the battlefield, after hours of combat, adrenaline fatigue means that "the only things moving are the pupils of their eyes". This is why they say goodbye to one another prior to each call to combat. When under fire, Wright perceives, "they would still be together, but they wouldn't really be seeing one another for a while, since each man would be in his own way sort of gone".

'The Killer Elite' is compulsive reading. Yet the high drama of the narrative seems paradoxical given the monastic tedium and surreal levels of physical attrition the Marines suffer. It is a rare night when they are allowed more than two hours sleep, and for days on end they don't sleep at all. Their feet rot in their boots, their eyes swell in the dust storms, they eat freeze-dried coffee straight from the packet and masturbate on duty just to stay awake. In a letter home to his wife and child, one Marine writes, "I see dead people and children everywhere and function in a void of indifference. I keep you and our daughter deep down inside, and I try not to look there".

"I try not to look there" What is the marine afraid to see? Who he used to be, perhaps, or what his life before the Iraqi desert was like. But Wright never turns his gaze, and nor do we. 'The Killing Elite' is a spectacle of fighters whose moral compasses have been twisted into unfamiliar forms. So too are The 'Bourne' films, 'The Dark Knight Trilogy', and the television show '24'. Except Wright's account isn't one of those, the usual.

The reluctance of many war veterans to share their military experiences is well known. Peacetime civilians acknowledge that there is much about the lived experience of warfare that may be impossible to communicate. We demonstrate this on Rememberance Day and Anzac Day each year when we observe a minute's silence not only to honour the fallen but to humble ourselves before the collective horror of their experiences and our preservation from them. We can bear witness to their suffering but are blessed not to feel it. For this, too, in our quietude we give thanks.

Wright's account of the 2003 invasion isn't quiet. Nor will Bigalow's be. The very concept of a dramatic recreation and of an embedded reporter speaks against it. Much virtuosity exists in how these writers and filmmakers are able to make us feel closer to the experience of combat. But we also know the lights will always come up and we can leave the room with our selves intact. "Whatever last shred of humanity I had before I came here, it's gone", murmurs a Marine in Wright's battalion. We can read of his actions, shudder at images of his surrounds and be hypnotised by an actor who portrays him but the inner truth of his trauma, and his loss, we can never know.

Paul D. Carter, PhD

Ending violent conflict and building world peace

By: Jody Williams, Jeremy Gilley, and Scilla Elworthy

Jody Williams: A realistic vision for world peace

December 2010, Washington, DC

In more than 100 years of Nobel Peace Prizes, only a dozen women have ever won. Civil-rights and peace activist Jody Williams received the award in 1997 as the chief strategist of the International Campaign to Ban Landmines, which established the first global treaty banning antipersonnel mines. Williams believes that peace is defined by human (not national) security and that it must be achieved through sustainable development, environmental justice, and meeting people's basic needs. To this end, she co-founded the Nobel Women's Initiative, endorsed by six of seven living female Peace laureates. She chairs the effort to support activists, researchers, and others working toward peace, justice, and equality for women and thus humanity. Williams also continues to fight for the total global eradication of landmines.

Jeremy Gilley - One day of peace

July 2011, Edinburgh, Scotland

For the past 10 years, filmmaker Jeremy Gilley has been promoting September 21 as a true international day of ceasefire, a day to carry out humanitarian aid in the world's most dangerous zones. The practical challenge starts with: how to convince both parties in a conflict to put down their weapons and trust the other side to do the same? But Gilley has recorded successes, including in 2008 when 1.85 million children under the age of five, across seven Afghan provinces (where conflict has previously prevented access), recieved the polio vaccine.

Scilla Elworthy: Fighting with non-violence

April 2012, Exeter, UK

When Scilla Elworthy was 13, she sat in front of her television set watching as Soviet tanks rolled into Budapest. Immediately she started packing her bags. "What are you doing?" her mother said. "I'm going to Budapest," she said. "They're doing something awful and I have to go." Years later, Elworthy is a three-time Nobel Peace Prize nominee and a recipient of the Niwano Peace Prize. In 2002 Elworthy founded Peace Direct, which supports local action against conflict, and in 1982 founded Oxford Research Group, a think-tank devoted to developing effective dialogue between nuclear weapons policy-makers and their critics.

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Trauma and world literature: They also serve ... when a service member is wounded, a family is wounded

By: Harold Kudler

In the poem, "On His Blindness" (1655), John Milton (1608-1674), considers whether his loss of sight and subsequent inability to fully employ his G-d given abilities will diminish him in the eyes of G-d. He concludes instead that G-d is most satisfied with those who best bear their burdens: "They also serve who only stand and wait" (line 14).

That 17th century epigram may also be applied to the families of service members and veterans. Military family members may not deploy to the combat area but they none-the-less serve by standing and waiting. And sometimes that waiting doesn't end with the deployment. This is strikingly illustrated by Charles Coleman in his 1980 novel, Sergeant Back Again. Coleman's novel of the Vietnam War, inspired by his own service in that war, has recently been released in a 30th anniversary edition embedded within a new anthology of critical and clinical commentary. For full disclosure, I want to point out that I contributed a psychiatric perspective within that commentary.

At the conclusion of Sergeant Back Again, the protagonist, Army medic Andy Collins, notices "a young woman sitting on a bench with an old man in the restricted-No-Visitors-Allowed-area" (p.284). The man turns out to be Collins" former commanding officer in Vietnam, now shriveled and demented, "wasted" by the burdens of war. The young woman is his daughter, Ginger.

> As Collins contemplates "the crazed expression on the face of his commanding officer" (p.286), he says:
>
> "None of us will ever really come home again, Ginger. There is no coming back home when your beliefs are destroyed, your soul shattered. We are war orphans, as a friend of mine once said."
>
> "So am I, Andy." Collins looked inquisitively at Ginger.
>
> "I'm a war orphan too," she repeated. "I've lost a father. I mean, this is not the man I've known for 20 some years."
>
> Collins was about to say that you can be an orphan to yourself. But as the meaning of Ginger's statement beckoned his empathy, it occurred to him that there was a bond between the veterans and their families that went way beyond the battlefield. He realized then that the possibility of making some sense of the non-sense was not the futile plea of a madman. (pp. 286-7)

Veterans of all wars and all their families serve in ways not always recognized by the public at large. The United State Department of Defense and Department of Veterans Affairs are making innovative strides in serving the nation's war fighters within the context of their families. While these efforts have been prompted by recent wars, they also "lift boats" for all generations.

Charles Coleman has recently founded the PTSD Press to promote greater awareness of the causes, conditions, effects and treatment for survivors of traumatic events and publish relevant, compelling and thought-provoking insights into traumatic events and environments by portraying and documenting individuals in crisis and their outcomes.

Citation

Milton, John, (1655) On His Blindness in Quiller-Couch, Arthur Thomas, Sir. The Oxford Book of English Verse. Oxford: Clarendon, 1919, [c1901]; Bartleby.com, 1999. www.bartleby.com/101/. [Accessed July 31, 2011).

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Kudler, H. (2012). Trauma and world literature: They also serve ... when a service member is wounded, a family is wounded. *Stress Points, Spring,* 23.

ASTSS Research Award recipients 2012

Every year ASTSS rewards academic excellence with three prizes designed to acknowledge and encourage new researchers in the field of traumatic stress. At this year's Australasian Conference On Traumatic Stress (ACOTS) Miyuki Ono was awarded first prize for her study into overgeneral memory retrieval with survivors of adult or childhood trauma. Karen Teshuva's research exploring experiences of aged care and aging by genocide survivors was awarded second prize, whilst third prize was awarded to Mohamud Osman for research into former refugees coping after the NZ earthquakes. ASTSS extends its congratulations to the Research Award recipients. For more information on the Research Awards click here.

First Prize

Trauma and self-discrepancy in overgeneral memory retrieval

Miyuki Ono - Griffith University

The aim of this study was to examine the contributory role of childhood and adulthood trauma and appraisal of self-discrepancy in over-general memory retrieval (OGM) in a non-clinical sample. Participants with a history of childhood trauma (n = 29); adulthood trauma only (n = 17) or no-trauma (n = 26) participated in this study. The childhood trauma group showed a significantly higher level of general negative memory retrieval than the no-trauma group. Conversely, the adult-hood trauma group showed a significantly higher level of general threat memory retrieval than the non-trauma group. People with a history of trauma displayed an increased level of generalised memories to negative cues. Distress relating to the perceived similarity between participants' 'Actual self' and 'Feared self' significantly predicted the level of OGM, even after controlling for the impact of a history of trauma.

Second Prize

Experiences of Aging and Aged Care in Australia among older survivors of genocide

Karen Teshuva - Latrobe University

This qualitative study investigated the ageing and aged care experiences in Australia of two cohorts of older survivors of genocide: Jewish Holocaust survivors and older Cambodian genocide survivors. It was carried out in response to an identified need to better train aged care workers who are in contact with these groups. In-depth interviews were conducted with 21 community-dwelling survivors aged 65 and over. Credibility was ensured by methodological triangulation and peer debriefing. The study highlighted the importance of under-standing older survivors in the context of their entire life course and in terms of both vulnerability and resilience. It showed that trauma history can heighten older survivors" sensitivity to many aspects of the social and physical environments in residential, community, and home-based aged care settings. The study also uncovered the potential for aged care to help older survivors cope with the psychosocial and emotional effects of resurfacing post traumatic stress symptoms. This study has implications for care practice and staff training. Care workers require specialised knowledge about the long-term effects of extreme trauma and strategies for developing trust and minimising emotional distress. By contributing to the literature on caring for older survivors, this study may help prepare care workers in Australia to support older people from more recently arrived refugee groups and their families.

Third Prize

Christchurch earthquakes: how did former refugees cope?

Mohamud Osman - University of Canterbury

Aim: This study investigated how former refugees now living in Christchurch communities coped after the 4 September 2010 and subsequent earth-quakes.

Method: A systematic sample of one in three former refugees from five ethnic groupings (Afghanistan, Kurdistan, Ethiopia, Somalia and Bhutan) was selected from a list of 317 refugees provided by the Canterbury Refugee Council and invited to participate in the study. Seventy two out of 105 potential participants completed a 26 item questionnaire regarding the impact of the quakes, their concerns and anxieties, coping strategies and social supports. The methodology was complicated by ongoing aftershocks, particularly that of 22 February 2011.

Results: Three quarters of participants reported that they had coped well, spirituality and religious practice being an important support for many, despite less then 20% receiving support from main-stream agencies. Most participants (72%) had not experienced a traumatic event or natural disaster before. Older participants and married couples

with children were more likely to worry about the earthquakes and their impact than single individuals. There was a significant difference in the level of anxiety between males and females. Those who completed the questionnaire after the 22 February 2011 quake were more worried overall than those interviewed before this.

Conclusion: Overall, the former refugees reported they had coped well despite most of them not experiencing an earthquake before and few receiving support from statutory relief agencies. More engagement from local services is needed in order to build trust and cooperation between the refugee and local communities.

Stress Points
Advancing Trauma Recovery and Research

Stress Points is a quarterly ejournal produced by the Australasian Society for Traumatic Stress Studies (ASTSS). It aims to report and examine current developments in research, theory, clinical practice, social policy and inquiry in the field of trauma and posttraumatic mental health, with contribution and dissemination beginning with ASTSS members. Members and non-members can make contributions in the form of feature articles, reviews, interviews, research reports, meta-analyses or opinion pieces - all with the primary focus on trauma.

The themes of upcoming editions of *Stress Points* are (please note date changes):

Summer 2013
Released: February 2013
New Programs and Projects in Trauma
Submission deadline: January 11 2013

Autumn 2013
Released: May 2013
Trauma and the Indigenous Experience
Submission deadline: April 11 2013

All contributions must be consistent with the stated mission of ASTSS: (1) to advance knowledge about the nature and consequences of highly stressful events, (2) to foster the development of policy, programs and service initiatives which seek to prevent and/or minimise the unwanted consequences of such experiences,and (3) to promote high standards and ethical practices in the trauma field.

Submissions can be made at the *Stress Points* Portal at http://www.astss.org.au or emailed directly to the editor at ejournal@astss.org.au

Acknowledgements and Credits

Stress Points, Spring, 2012

Editor - Bronwyn Tarrant
Subeditor - Andrew Masters
ASTSS President - Professor Justin Kenardy

Papers contributed by: Paul D. Carter, Claudia Catani, Anne-Laurie Couineau, David Forbes, Nick Ford, Katherine Hawkins, Harold Kudler, Delyth Lloyd, Des Perry, and Jeffrey V Rosenfeld.

Related Podcast with Professor Alexander McFarlane

Thanks to: The National Film Preservation Society, Ted Talks, Jody Williams, Jeremy Gilley, Scilla Elworthy, ISTSS Traumatic Stress Points, and Jaryd Fletcher.