

**Final Program**

**PTSD & Complex PTSD III:  
Treatment, Research, and  
Practical Applications**

June 25th - 27th, 2004

The Coast Plaza Suite Hotel at Stanley Park  
1763 Comox Street  
Vancouver BC, Canada

Conference organizers:

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# Welcome!

Welcome to our 2004 Vancouver Trauma Conference!

We are delighted to have Drs. Chris Brewin, Rachel Yehuda, and Alexander McFarlane, all distinguished experts in the field of posttraumatic stress, join us this year.

Dr. Brewin hails from the United Kingdom and will be speaking on Friday morning and part of Friday afternoon on Memory and Identity in PTSD. Traumatic events that result in PTSD have strong effects on memory processes that affect the individual's ability to function on a day-to-day basis. Facing traumatic events can also affect identity - the individual's experience of themselves, others, and the world may change significantly. Dr. Brewin discusses two processes involved in memory disruptions with PTSD, which may involve competition between sensory memory and verbal memory and identity. A description of Dr. Brewin's talk can be found in the Plenary Presentations section of this booklet.

Findings from empirical research suggest that experiencing traumatic events and resultant PTSD may alter the neurobiological functioning of the brain. Dr. Yehuda will discuss research on biological changes that occur in the immediate aftermath of experiencing a traumatic event, and how such biological changes may function either as risk factors for the subsequent development of PTSD, or may have an impact on how PTSD negatively affects physiological functioning. A description of Dr. Yehuda's presentation on Saturday is in the Plenary Presentations section of this booklet.

Dr. Alexander McFarlane is coming to Vancouver from Australia. His plenary address on Sunday involves the effects of posttraumatic stress on information processing - particularly of short term memory processes. Research suggests that these impairments in working memory interfere with the individual's ability to distinguish between relevant and irrelevant information in the environment. Dr. McFarlane will also discuss the implications of these findings on treatment approaches. A description of Dr. McFarlane's address may be found in the Plenary Presentations section of this booklet.

Our workshop faculty consists of experienced clinicians who will share their knowledge and practical information with regard to working with special trauma populations. Workshop descriptions are located in the Workshop section of this booklet. In addition, poster sessions will be on exhibit throughout the conference in the Conference Foyer on the Conference level. Poster descriptions follow the Workshop section.

Thank you for joining us! We hope not only that you find the presentations intellectually stimulating, but that you take the time to engage in self-care and get to know your colleagues in an informal, relaxing environment at the reception and during refreshment breaks. Also, be sure to not miss Vancouver's International Jazz Festival, June 19-30 (website: <http://www.coastaljazz.ca/jazzfest2004/>)

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# Continuing Education Accreditation

**Physicians:** As an organization accredited to sponsor Continuing Medical Education for physicians by both the Committee on Accreditation of Canadian Medical Schools and the Accreditation Council for Continuing Medical Education of the United States, the Division of Continuing Medical Education, UBC, designates this educational program as meeting the criteria for 17.5 AMA credit hours in Category 1 of the Physicians Recognition Award (PRA) of the American Medical Association (AMA) or any other organization that recognizes Category 1 credits. This program meets the accreditation criteria of the College of Family Physicians of Canada and has been accredited for 17.5 MAINPRO-M1 Credits. It is also eligible for Maintenance of Certification Section 1 Credits of the Royal College of Physicians and Surgeons of Canada.

**Psychologists:** The program has been approved by the **Canadian Psychological Association** for 19 Continuing Education credits for Psychologists. This program has been reviewed and approved for CE credit for psychologists by the **American Psychological Association's** Continuing Professional Education Committee. The provider maintains responsibility for the delivery of the program. Approval #04-061.

**Counsellors:** The program has been approved by the **Canadian Counselling Association** for 3 CEUs (equivalent to 18 hours of instruction) for Counsellors.

**Others:** Bring your general certificate of attendance (in your registration package) to your local organization.

## Important Note Regarding Continuing Education Sign- In

**Psychologists** who will be applying for CEUs through the Canadian or American Psychological Associations must sign in and out of each session at the CEU desk in the foyer. Forms for CEUs from the CPA will be available for pickup at the CEU desk at the end of the conference, and are to be submitted to the CPA by the attendee. A list of psychologists who seek CEUs through the APA and who have paid the \$25 fee will be sent to the APA following the conference.

Canadian and American **physicians** who want CME credits must sign the attendance sheet each day on the CEU desk in the foyer. A list of those who seek CMEs will be sent to the CME office at UBC, and certificates will be sent to you from UBC.

**Counsellors** who seek credits from the Canadian Counselling Association can pick up the relevant form at the CEU desk at the end of the conference.

All others do **not** need to sign in or out. General certificates of attendance are located in your registration package.

## General Information

### Registration Desk

The registration desk will be situated in the main Ballroom Foyer on the Conference level. The desk will be open from 8:00 - noon and from 12:30-3:30 pm.

### Badges

The conference badge that you receive with your on-site registration is required for admittance to all sessions. We ask that you please wear your badge during attendance.

### Meeting Evaluation

Your assistance is needed to help improve future conferences. Please return your completed evaluation forms at the end of the conference (a box will be provided at the registration desk).

### Smoking Policy

All function rooms and foyers are designated non-smoking in accordance with the City of Vancouver

## Sponsors



Janssen-Ortho Inc.

## Vancouver General Hospital PTSD Clinic Foundation

The VGH PTSD Clinic was established May 1, 2003 after GlaxoSmithKline donated an unfettered grant of \$100,000. The Clinic conducts PTSD assessments, individual therapy, group therapy and research. To date no government funding has been provided specifically to this clinic. The VGH PTSD Clinic Foundation was established at VGH to accept tax deductible donations to help fund the ongoing operating costs of the clinic. Any individuals or organizations donating \$1000 or more will have their name displayed on a plaque in the hospital.

## Welcome Reception

We extend an invitation to all delegates to attend the Welcome Reception on Friday evening, Windows on the Bay (35<sup>th</sup> floor), from 6 pm - 8 pm. We will be serving Hors D'Oeuvres with a cash bar. The reception will provide opportunities for you to get to know colleagues who are working in the trauma field, and will also provide an opportunity for delegates to interact in a more relaxed setting. We encourage you to come on up!

## Tape & CD Sales

Tapes and CDs of individual sessions may be purchased at the Tape Desk in the foyer on the Conference level. Tapes and CDs may also be ordered after the conference by contacting Ken Andrews at Precision Sound ([kandrews@precisionsound.com](mailto:kandrews@precisionsound.com)).

## Exhibitors

Odin Books

Precision Sound Tape/CD Sales

The Canadian Foundation for Trauma Research & Education (CFTRE)

B.C. Art Therapy Association

Edgewood

Free—Take One table

## Quiet Reflection Room

The Barclay/Gilford room on the Conference level of the hotel will be available during the day on Friday and Saturday for delegates who would like a quiet place away from the hustle and bustle of the main conference. The Barclay/Gilford room opens onto the Garden Terrace, which is also very calming and relaxing (weather permitting).

# Schedule

## Friday June 25<sup>th</sup>, 2004

Time	Event	Location
8 am - 3:30 pm	Registration	Denman Ballroom Foyer
8 am - 5:30 pm	Exhibits and Posters	Conference Foyer
8 am - 9 am	Continental Breakfast	Denman Ballroom Foyer
9 am - 10 am	Plenary Session I: Memory and Identity in PTSD: A new perspective on trauma and its treatment by Chris Brewin	Denman Ballroom
10 am - 10:30 am	Refreshment Break	Conference Foyer
10:30 - 12 pm	Plenary Session I: Memory and Identity in PTSD: A new perspective on trauma and its treatment by Chris Brewin	Denman Ballroom
12:00 - 1 pm	Lunch	On your own
1 pm - 3 pm	Plenary Session I: Memory and Identity in PTSD: A new perspective on trauma and its treatment by Chris Brewin	Denman Ballroom
3 pm - 3:30 pm	Refreshment Break	Conference Foyer
3:30 - 5:30 pm	Workshops	See Table Below
6 pm - 8 pm	Welcome Reception	Windows on the Bay

3:30 – 5:30 pm	<b>Friday Workshops:</b>	<b>Location:</b>
	I. Medico-legal Issues in PTSD (Wanis)	Nelson Room
	II. First Nations' Trauma Issues & Treatment (McCormick)	Denman Room
	III. Working with Traumatized Children (Wieland)	Comox Room
	IV. Recognizing Psychological Trauma in the Family Practice Office (Knell & Scalzo)	Gilford Room
	V. Holographic Reprocessing (Katz)	Barclay Room
	VI. Vicarious Trauma (Koverola)	Pacific Room
	VII. Psychiatry and Art Therapy (Brasfield & Clarkson)	Beach Room
VIII. Working with Adolescent Females (Bell-Gadsby & Clark)	Parkside Room	

<b>Saturday June 26<sup>th</sup>, 2004</b>		
<b>Time</b>	<b>Event</b>	<b>Location</b>
8 am – 3:30 pm	Registration	Denman Ballroom Foyer
8 am – 5:30 pm	Exhibits and Posters	Conference Foyer
8 am - 9 am	Continental Breakfast	Denman Ballroom Foyer
9 am – 10 am	Plenary Session II: Neurobiology of Acute Stress Response and Posttraumatic Stress Disorder (PTSD) by Rachel Yehuda	Denman Ballroom
10 am – 10:30 am	Refreshment Break	Conference Foyer
10:30 – 12 pm	Plenary Session II: Neurobiology of Acute Stress Response and Posttraumatic Stress Disorder (PTSD) by Rachel Yehuda	Denman Ballroom
12:00 – 1 pm	Lunch	On your own
1 pm – 3 pm	Plenary Session II: Neurobiology of Acute Stress Response and Posttraumatic Stress Disorder (PTSD) by Rachel Yehuda	Denman Ballroom
3 pm – 3:30 pm	Refreshment Break	Conference Foyer
3:30 – 5:30 pm	Workshops	See Table below

3:30 – 5:30 pm	<b>Saturday Workshops</b>	<b>Location</b>
	I. Neuroimaging and the Traumatized Brain (Lanius)	Nelson Room
	II. Building Bridges in the Canadian Military (Brock et al.)	Denman Room
	III. Words Aren't Everything: The Trauma Art Technique (Bills)	Comox Room
	IV. Recovery from the Four Horsemen of Marital Discord (Williams-Keeler)	Gilford Room
	V. Psychological Trauma in the Family Practice Setting (Knell et al.)	Barclay Room
	VI. Integrating Research and Clinical Practice: Challenges in the Clinical Application of Attachment Constructs to Adult Survivors of Child Abuse (Templeton, et al.)	Beach Room
VII. Transgenerational trauma of colonization and abuse: A performative suicide prevention approach with First Nations youth (Giard)	Pacific Room	

<b>Sunday June 27<sup>th</sup>, 2004</b>		
<b>Time</b>	<b>Event</b>	<b>Location</b>
8 am – 3:30 pm	Registration	Denman Ballroom Foyer
8 am – 5:30 pm	Exhibits and Posters	Conference Foyer
8 am - 9 am	Continental Breakfast	Denman Ballroom Foyer
9 am – 10 am	Plenary Session III: Information Processing Disorders in PTSD by Alexander McFarlane	Denman Ballroom
10 am – 10:30 am	Refreshment Break	Conference Foyer
10:30 – 12 pm	Plenary Session III: Information Processing Disorders in PTSD by Alexander McFarlane	Denman Ballroom
12:00 – 1 pm	Lunch	On your own
1 pm – 3 pm	Plenary Session III: Information Processing Disorders in PTSD by Alexander McFarlane	Denman Ballroom
3 pm	Conference Adjourns	

# Presentation Abstracts

All plenary sessions begin at 9am and end at 3 pm. There will be a mid-morning and mid-afternoon break, as well as lunch break. Plenary sessions are held in the Denman Ballroom on the Conference Level.

## FRIDAY PLENARY

### **Memory and Identity in PTSD: A new perspective on trauma and its treatment**

by Chris R. Brewin

Many central aspects of PTSD, such as the coherence of the diagnosis, how traumas can be relived in the present, and what it means to "process" or "transform" a trauma memory, are poorly understood at present. A major reason is that PTSD appears to incorporate two quite separate sets of processes. One of these is concerned with specific reactions to extreme threat, including the activation of the HPA axis and the release of catecholamines and stress hormones. The effects on brain structures such as the prefrontal cortex, hippocampus, and amygdala promote the encoding of long-lasting image-based memories but interfere with the encoding of verbal or narrative memories. The construction of adequate verbal memories containing contextual information is a form of fast learning necessary to represent the trauma as a past event and inhibit the repeated reliving of the trauma. Retrieval competition then takes place between these verbal memories and image-based memories in the presence of trauma cues. The second set of processes is concerned with the challenge the trauma poses to the victim's identity, either by undermining positive identities or reinstating previous unwanted identities. This challenge can be overcome with a special form of slow or interleaved learning that enables positive identities to compete more effectively for retrieval. The most parsimonious explanation of spontaneous recovery and treatment suggested by recent research is that "trauma processing" leaves original trauma memories intact and instead involves the construction of alternative, verbal memories. Both these new memories, and new or pre-existing positive identities, are then helped to compete more effectively for retrieval in the presence of reminders of the traumatic event.

#### **Reference**

Brewin, C.R. (2003). Post Traumatic Stress Disorder: Malady or myth? New Haven: Yale University Press.

**Learning objectives:** Participants will acquire knowledge of recent research on the neurobiology of memory and will be able to relate this to mechanisms of psychological treatment. They will become familiar with mechanisms by which trauma poses challenges to identity and will incorporate consideration of these issues into assessment and treatment.

## SATURDAY PLENARY

### **Neurobiology of Acute Stress Response and Posttraumatic Stress Disorder (PTSD)**

by Rachel Yehuda

In recent years, there has been increased focus on examining biologic alterations in the acute stress response so as to determine the relationship between these alterations and the subsequent development of PTSD. This presentation will provide a review of these investigations. Since not all trauma survivors develop PTSD, it has been particularly important to try and determine whether there is biologic heterogeneity in the early aftermath of trauma - that may be relevant to either biologic risk for PTSD or its pathophysiologic expression. There are now numerous studies in the literature that have examined persons anywhere from hours, days, and weeks following trauma. Particularly informative have been longitudinal biologic studies, sampling persons at multiple times in the aftermath of trauma. In the aggregate, these studies have suggested that differences in heart rate and cortisol responses may differentiate persons at risk for the development of PTSD. However, there may be specific differences in trauma-related biologic alterations relating to gender, type of trauma, and prior risk. These and other findings will be reviewed

#### **Learning Objectives**

This course is designed to help you:

1. Identify biologic alterations in acute stress response and their relationship to the development of PTSD
2. Identify risk factors for development of PTSD

## SUNDAY PLENARY

### **I nformation processing disorders in PTSD: How trauma disrupts the capacity to manage day to day information**

by Alexander McFarlane

A major focus in the aetiological hypotheses about post traumatic stress disorder, is the primary role of the traumatic memory as the driver of symptoms. It is also presumed that the primary difficulties with memory in PTSD relate to the processing of the traumatic memory. The current treatment strategies are driven by these hypotheses, with the predominant psychological therapies aiming to assist the individual in re-processing or reconceptualising the traumatic memory. An alternative hypothesis is that the ability of individuals to organise information independent of whether it is traumatic or not is disrupted in PTSD. A significant body of research has been done examining the working memory in individuals with post traumatic stress disorder and significant abnormalities have been found. Thus, people with post traumatic stress disorder do not simply have difficulties in dealing with trauma related laden information, but also have significant problems in organising their day to day environment. Their working memory abnormalities suggest that they have a difficulty in defining salient and highlighting relevant features of their day to day environment. This can both lead to major problems with concentration and memory because of the inability to focus, but also to emotional numbing and social withdrawal.

A series of neuroimaging studies will be presented that characterise these working memory abnormalities. The relevance to treatment will then be discussed, both in relation to psychological as well as pharmacological treatments. Several novel approaches to addressing this dimension of PTSD will be discussed. In particular, the ability of an individual to modulate their arousal and the way that this influences their information processing biases will be described.

#### **Learning Objectives**

1. To understand the nature of working memory and its relevance to post traumatic stress disorder.
2. To understand the different methods of neuroimaging and how they characterise distinct domains of neural functioning.
3. To understand the difference between traumatic memories and the working memory abnormalities in PTSD and the relevance to treatment.

## FRIDAY WORKSHOPS

Workshops run concurrently from 3:30 until approximately 5:30 (there may be some slight variation in end times).

### **I. First Nations' Trauma Issues and Treatment**

by Rod McCormick, PhD

Canada's attempt to assimilate Aboriginal people resulted in over a century of physical, sexual, emotional, and spiritual abuse of Aboriginal children. This legacy led to several generations of traumatized victims, who in many cases, have gone on to perpetuate this cycle of abuse and oppression within their own families. Despite attempts made by the federal government and churches responsible to remedy these wrongs, the impact of this century of abuse has not diminished. Healing approaches developed by Aboriginal people and by various non-native therapists have shown promise in recent years. This workshop will highlight those successful healing strategies and provide participants with an awareness of relevant cultural considerations for Aboriginal people as well as their remarkable journey towards recovery and health.

**Learning Objectives:** This workshop is designed to

1. Provide participants with an awareness of the unique nature of PTSD and Complex PTSD amongst Aboriginal peoples.
2. Most importantly, the workshop will focus on culturally specific and effective treatment strategies.

**Location:** Nelson Room (Conference level)

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### **II. Medico- legal Issues in PTSD**

by Wahan Wanis, MD, FRCPC

An initial discussion of legal terminology and diagnostic criteria as it applies to mental disorders (specifically PTSD) and legal judgments will be given. Distinction between burden of guilt in civil versus criminal cases will be described. Malingering and PTSD will be reviewed and validity of symptoms discussed. The essentials of writing medical legal referrals and reports will be reviewed. A plea/judgment of NCR MD (Not Criminally Responsible due to Mental Disorder) will be defined and some of the precedent setting cases will be briefly described. A review of some recent PTSD legal cases and their outcomes will be discussed.

**Learning Objectives:** This course is designed to help you

1. become aware of basic legal terminology in regards to PTSD and mental disorders;

2. learn the diagnostic criteria and legal interpretation for Not Criminally Responsible due to Mental Disorder (NCR MD), specifically PTSD;
3. learn the essentials for a composing a Medical Legal Report and determining validity of symptoms

**Location:** Denman Room (Conference level)

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### **III. Working with Traumatized Children: Identifying and shifting early implicit memories and dissociative characteristics**

by Sandra Wieland, PhD, R. Psych.

Children who have experienced early neglect and/or abuse come into care and into therapy with neuronal patterning that perpetuates the early experiences. This workshop will discuss the effects of early trauma on brain development and how the early implicit memories related to attachment and to negative and positive experiences will be played out in the child's new setting. Ideas for eliciting implicit memory during therapy (information from caregivers, early and ongoing fears and anxieties, nightmares and flashbacks, somatic responses, problematic behaviours, behaviours with caregiver, play, art, and sandtray themes) will be discussed. Therapeutic techniques for shifting the imprint (neuronal patterning) from these early experiences will be described (dyad work with caregiver, responding to play and art themes, EMDR). The important roles of parents, child and youth workers, and case social workers with these children will be highlighted and ideas will be given for interactions that help to shift the child's early implicit learning. Particular attention will be given to recognizing the presentation of dissociation in children and providing integrative experiences. The different roles of parent-figures, child and youth workers, agency social workers, and therapists will be described. The importance of each will be highlighted within a team-approach for helping traumatized children.

#### **Learning Objectives:**

1. increase understanding of the effects of early trauma (neglect, emotional abuse, physical abuse, sexual abuse, witnessing violence) on brain development
2. learn ways to identify, elicit and shift children's trauma-created implicit memories
3. recognize dissociative defenses and increasing the child's integrative neuronal networks

**Location:** Gilford Room (Conference level)

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## **IV. Recognizing Psychological Trauma in the Family Practice Office**

By Eva Knell, MD CCFP, FCFP, & Olivia Scalzo, PhD

How does psychological trauma present in the family practitioner's office? Dr. Eva Knell will facilitate discussion amongst participants exploring this question by reflecting their own clinical experiences and applying knowledge gained from this conference and other sources. The discussion will be preceded by a brief didactic session focused on psychological trauma in primary care settings and accompanied by references. Dr. Olivia Scalzo will provide expertise in the area of psychological trauma and its presentation in obstetrical care. It is hoped that participants in this discussion session will come from a wide range of disciplines, including but not limited to psychology, psychiatry, social work, counseling, nursing, family therapy, and medicine.

### **Learning Objectives:**

1. To recognize signs/symptoms that traumatized persons present with in primary care settings
2. To recognize signs/symptoms that traumatized women present with in obstetrical settings.

**Location:** Gilford Room (Conference level)

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## **V. Holographic Reprocessing: A new perspective on revisiting trauma**

by Lori S. Katz, PhD

In this workshop, participants will learn several new therapeutic techniques to treat trauma. Current models of exposure therapy instruct clients to "re-live" their experience of trauma "as if it were happening right now." In contrast, in Holographic Reprocessing, clients revisit their trauma from the vantage point of an observer. This method produces minimal arousal and distress while facilitating the integration and completion of unresolved aspects of trauma. Participants will learn the distinctions of various exposure-based therapies, and the specifics of how to practice Holographic Reprocessing. Case examples are used to illustrate the concepts.

### **Learning objectives:**

Participants will learn...

1. the distinction between field vs observer vantage point in recalling trauma
2. three techniques to broaden the context of a traumatic incident (such as "finding multiple truths," and "age comparison").
3. six techniques to ensure minimal arousal during exposure (such as "maintaining an observer vantage point," and using the "hindsight advantage").

Participants will also learn...

4. five goals for reprocessing (such as completing communications, releasing and integrating affect, and returning to safety), and
5. three techniques to achieve those goals using imaginal rescripting, fantasy, and role-playing.

**Location:** Barclay Room (Conference level)

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## **VI. Vicarious Trauma: When you Can't Just Leave it at Work**

by Catherine Koverola, PhD

Flashing back to a distressing therapy session, more absent minded than usual, numbing out, wishing a client would no show, notions of a career change, irritability, nagging self doubts, conflict in your own interpersonal relationships, disillusioned with life in general....your family says "just leave your work at work".... but can you? Numerous clinicians, particularly those who treat traumatized clients, experience Vicarious Trauma as a result of their work. Vicarious Trauma is an occupational hazard; left unrecognized and unaddressed it has the potential to devastate the clinician both personally and professionally. The good news is that when vicarious trauma is recognized and addressed, the clinician can be fully equipped to effectively treat even the most traumatized of clients while maintaining their own physical and emotional health. This workshop will present a conceptual model on the process of vicarious trauma. Participants will be encouraged to assess the degree to which they are vicariously traumatized. Finally participants will be presented with a model on how to develop a self care plan to address vicarious trauma.

### **Learning Objectives:**

1. Participants will understand the process of vicarious trauma and its impact upon clinical practice
2. Participants will be able to utilize a conceptual model to address vicarious trauma within themselves
3. Participants will complete a self assessment of their vulnerability to vicarious trauma and their current status
4. Participants will be introduced to a framework on how to develop a viable self care plan to address vicarious trauma and to prevent future vicarious trauma

**Location:** Pacific Room (7<sup>th</sup> floor)

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## **VII. Psychiatry and Art Therapy: An integrative model for treatment of First Nations trauma**

by Charles Brasfield, MD, PhD, FRCPC & Peggy Clarkson, MA, ATR, RCC, RCAT

The patient population that is the focus of this workshop begins with First Nations people originally traumatized in childhood, many of whom have been waiting up to 50 years to begin to process their experiences. This group is followed by their siblings, spouses, children and grandchildren, some of whom have experienced repetitive sexual trauma for a period of years up to the present. A collaborative program involving both psychiatry and art therapy has been developed serving one particular community and the focus of the workshop in part will be to examine the formation, functioning and denouement of this particular program. Consideration will be given to the political realities of clinical services, funding needs, lacks and possible future directions.

**Learning objectives.** At the end of this workshop you will:

1. Be more aware of the structure and inter-generational nature of First Nations trauma, particularly sexual trauma
2. Understand how art therapy and psychiatry can complement each other
3. Understand how trauma predisposes First Nations survivors to substance abuse and Axis II diagnoses

**Location:** Beach Room (7<sup>th</sup> floor)

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## **VIII. Working with Adolescent Females Affected by Trauma: Innovations in Individual and Group Treatment**

by Cheryl Bell-Gadsby, M.A., R.C.C., M.F.C.C. & Natalie Clark, M.S.W., R.S.W.

This workshop will provide participants with a range of innovative and supportive interventions to address the unique impact of violence and trauma on adolescent girls. Grounded in current theories of adolescent female development and a relational model, this training will provide participants with treatment methods and tools for understanding and working with the expression of trauma in the daily lives and relationships of young women.

**Learning Objectives:**

Participants will:

1. Consider traumas currently experienced by young women including sexual harassment, peer victimization, date rape, sexual assault and sexual exploitation.

2. Identify adolescent female manifestation of these traumas in behaviors such as suicidal ideation, self-harming, depression, anxiety, phobias and disordered eating will be explored.
3. Develop new skills for working with this population including; specific methods for connecting and working with girls in a variety of settings both individually and in groups. Interventions will be explored on a continuum ranging from prevention, through brief crisis interventions, and treatment.

**Location:** Parkside Room (7<sup>th</sup> floor)

## SATURDAY WORKSHOPS

Saturday workshops run concurrently, and will be held from 3:30 until approximately 5:30. Times may vary.

### **I. Neuroimaging and the Traumatized Brain: PTSD and Emotion**

Ruth Lanius, MD FRCPC, PhD

Different experiential, psychophysiological, and neurobiological responses to traumatic reminders in Posttraumatic Stress Disorder (PTSD) have been reported in the literature. Two subtypes of trauma response have been hypothesized, one primarily dissociative and the other characterized predominantly by hyperarousal, each one representing unique pathways to chronic stress-related psychopathology. Recent neuroimaging findings with PTSD in our own laboratory support this notion and are consistent with the view that grouping PTSD subjects with different symptom patterns within the same diagnostic category may interfere with our understanding of posttrauma psychopathology. This workshop will integrate the findings of different responses to traumatic reminders with the symptomatology and neurobiology of PTSD.

#### **Learning Objectives**

1. To become familiar with different responses to traumatic reminders.
2. To become familiar with the brain structures underlying different responses to traumatic reminders.
3. To discuss the relationship between clinical symptoms of PTSD and the underlying neurobiology of the disorder.

**Location:** Nelson Room (Conference level)

## **II. Building Bridges in the Canadian Military Trauma Treatment Community**

Susan Brock, PhD, Greg Passey, MD, FRCPC, Lt. Col. Stephan Grenier, Vivienne Rowan, PhD, Lt. Col. David Wrather, Maj. Rakesh Jetly, MD, FRCPC

The road from fragmentation to integration in recovery from operational trauma requires a coordinated community effort involving numerous individuals and groups from across the country with a broad range of expertise and connection to the client. This workshop will introduce discussions regarding current initiatives and relevant issues related to both the development of such a community and to the unique challenges in working with a military/Veteran population. Topics for discussion will include: Development of online collaboration and support programs, how to streamline interactions with DND/VAC, the role of peer support from the perspective of the Operational Stress Injury Social Support Program, issues in coordinating and meeting assessment and treatment needs, development and funding of family support programs, and building vocational and community support. Panelists will include representatives from DND and VAC and mental health professionals specializing in military trauma from both the public and private sector. Attendees will be strongly encouraged to join the discussion and present their ideas, questions or comments regarding these topics.

### **Learning Objectives:**

1. Identification of current issues affecting trauma treatment with veteran populations
2. Discussion of the unique challenges in working with veteran populations and practical strategies

**Location:** Denman Room (Conference level)

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## **III. Words Aren't Everything: The Trauma Art© Technique**

Lyndra J. Bills MD (assisted by Anne Dietrich, PhD)

Psychotherapy often uses a verbal emphasis in its approach. For patients with PTSD or other trauma-based clinical problems there is a biological basis for using the nonverbal therapies. This workshop will draw attention to the biological basis for using creative or nonverbal therapies in treating patients with trauma-based disorders. In particular, the workshop will focus on one technique, Trauma Art©. It is a structured nonverbal cognitive exposure technique which is especially useful for reducing the intrusive symptoms of PTSD. There will be clinical examples of the use of Trauma Art© in treating PTSD in children and adults. Participants will have a chance to try this technique during the workshop. The experiential exercise will model the benefit of integrating both verbal and nonverbal therapies in trauma treatment.

**Workshop Objectives:**

1. Participants will gain an understanding of why the creative/nonverbal therapies are so important in treating clients with PTSD. They will be introduced to the psychobiology of traumatic memory processing and its connection to the nonverbal therapies.
2. Participants will learn about a specific nonverbal trauma technique called Trauma Art©. They will be able to have a basic understanding of how this technique may apply in their clinical setting.
3. Participants will be introduced to a framework for being able to conceptualize the use of any nonverbal/creative therapeutic technique. They will be able to understand the best times to apply these types of modalities in the course of treatment.

**Location:** Comox Room (Conference level)

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#### **IV. Recovery from the Four Horsemen of Couple Discord: Affect, Attachment, Autonomy, and Antagonism**

Lyn Williams-Keeler

Perhaps one of the most devastating correlates and effects of the incursion of trauma and the resultant symptomatology of Post-traumatic Stress Disorder involves the distressing ramifications for interpersonal relationships. In this workshop, we will endeavor to engender and promote hope for therapists who are willing to encounter the high levels of distress in the couple relationships of trauma survivors and to celebrate unique ways that, in partnership, recovery germinates. Trauma survivors are often facing overwhelming distress related to their sense of safety in an unsafe world, often made no safer by the presence of an intimate partner. In fact, there is probably no more dangerous enemy than an intimate enemy, who knows and who can exploit your vulnerabilities. This is often reflected in the black and white emotional palette that trauma survivors develop as a perspective on the world of relationship and it colours their view of the four attachment dimensions of esteem, trust, dependence and attitude toward attachment. In addition, there can be daunting levels of hostility, as well as attachment and affect dysregulation to deal with in the relationships of trauma survivors. However, in terms of enhancing the recovery environment for individual trauma survivors, we also know that safe, secure attachment is remedial. In fact, this may be the path to relief of the "allostatic attrition," "defaulted extinction" and "progressive sensitization" responses that Ari Shalev delineates as characteristic of chronic PTSD. Profound ruptures of trust and overwhelming affect are also cardinal indicators of Complex PTSD or DESNOS. Case studies will be referred to in order to exemplify the exploration of the pain of failed intimacy and the restoration of diminished identity concerns through the couple therapy process. This process draws on current knowledge about psychotraumatology, attachment theory, and couple therapy (including Emotionally Focused

Marital Therapy or EFT), as well as both the noise and silence inherent in these complex relationships where trust is always in jeopardy and love seems tantalizingly out of reach.

**Objectives:**

1. To illustrate five attachment styles, including disorganized attachment style, and to discuss examples of these in couples, in terms of complementary and antagonistic attachment styles
2. To discuss the complications of dissociative responses, dysregulated affect and disorganized/disoriented attachment indicators when partners are dealing with their own traumatic stress responses in the context of a challenging relationship
3. To illustrate with case examples, various therapeutic interventions to address the complexity of, and hope for, intimacy for trauma-survivor couples who implement dissociative and hostile responses, purposefully or inadvertently, as a way to withdraw from their partner and/or their own feelings.

**Location:** Gilford Room (Conference level)

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## **V. Psychological Trauma in the Family Practice Setting: Now what can I do?**

Eva Knell, MD, CCFP, FCFP, University of British Columbia; others to be announced

Family physicians are increasingly recognizing the symptoms of psychological trauma in the patients with whom they work. However this is often with the backdrop of limited resources available to the physician and patient. Discussants will consider current models of care and develop plans to assist patients in their specific setting. The session will be facilitated by Dr. Eva Knell with an interdisciplinary team. Participants from a broad range of disciplines are welcomed.

**Learning Objectives:**

1. Understand current models of care when treating patients with trauma histories
2. Learn how to develop plans to assist traumatized patients.

**Location:** Barclay Room (Conference level)

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## **VI. Transgenerational trauma of colonization and abuse: A performative suicide prevention approach with First Nations Youth**

by Monique Giard

This presentation includes the viewing of two short films created by fifteen First Nations youth involved in doctoral research on the role of performance and re-enactment in healing

trauma. Based on the work of Peter A. Levine (healing emotional scars and trauma through re-enactment), Lois Holzman & Fred Newman (performative psychotherapy) and Dennis Sullivan & Larry Tiffet (restorative justice), fifteen First Nations Youth perform stories of racist bullying and emotional injury through film and public workshops in Vancouver public schools. By re-enacting and performing stories of discrimination and abuse, and by becoming active participants in anti-bullying workshops, First Nations youth are able to elicit the help they need to resolve their grief, sorrow and the horrors of their parents and grandparents' residential schools' experiences. As part of the performative journey a healing ceremony was performed and Native youth were able to re-unite with their lost spirit. As a result of these performances, suicide-related activities diminished. "Our developmental concern leads us to help clients transform their life activity through reinitiating their capacity to perform, specifically, their capacity to perform conversation. This developmental, performative perspective has implications for the role of the therapist in relation to stories and narratives" (Holzman & Newman, 1999:103). Instead of 'acting out' in schools, First Nations youth are invited to 'act out' a head taller through performing anti-bullying workshops stories of trauma, abuse, and healing. The study shows that engagement with performative inquiry is a viable and necessary response to the challenges that inner city, at-risk First Nations youth face.

**Objectives of workshop:**

1. Greater awareness of Transgenerational Complex PTSD and its associated features and disorders.
2. Greater awareness of the impacts of both of performing trauma and the theory of re-enactment.
3. Greater awareness of culturally sensitive counselling with First Nations youth: Implications of First Nations traditional knowledge.

**Location:** Pacific Room (7<sup>th</sup> floor)

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## **VII. Integrating Research and Clinical Practice: Challenges in the Clinical Application of Attachment Constructs to Adult Survivors of Child Abuse**

Gillian Templeton BSc, Carol A. Stalker PhD, Kim Harper PhD, Gloria Cardey MSW

This workshop will explore how an intensive, in-patient six-week trauma treatment program for adults with a history of childhood abuse has attempted to use research findings to progressively inform program development. Workshop participants will have an opportunity to reflect upon and discuss the challenges of transforming quantitative data into practical interventions to promote an individual's healing. Results from a longitudinal study of 163 program clients indicated that attachment patterns and dimensions (as measured by West & Sheldon-Keller's Reciprocal Attachment Questionnaire) predict a substantial proportion of the variance in outcome at 6 months post discharge. Using this data to better understand who may not maintain gains made while in the program and to develop clinical interventions

to increase their potential for success has proven difficult. For example, subsequent attempts to clinically identify individuals who demonstrate these attachment patterns have challenged team assumptions and generated further questions about practical interventions. One avenue for intervention is within the program itself, for it is provided in a therapeutic community milieu setting. Clients are encouraged to explore patterns in their relationships with one another and with staff, with an emphasis upon developing healthy behaviours. Generalizing these behaviours to improve longstanding relationships that will be maintained post discharge is perhaps the largest challenge that clients face. Another opportunity for exploring how attachment pattern impacts these relationships is via a two-day workshop for friends and family members. A challenge associated with this initiative is in encouraging clients to invite significant people to attend the workshop. Family members and friends who do attend report benefits from the opportunity to explore how they are feeling and what they need. Often they disclose that they are struggling with experiences of secondary trauma and difficulties in the relationship with the client. This has raised questions of the interplay between attachment pattern and secondary trauma and suggests further research possibilities. The researchers, social worker and program coordinator will present the challenges they have experienced throughout the process of attempting to clinically apply research findings to further program development. The voices of program clients and family members will be heard via quotes and videotaped interviews.

**Learning objectives of workshop:**

1. Participants will be able to describe an example of how research findings and clinical practice influence one another in the process of ongoing program development. Participants will be encouraged to discuss similar experiences and to ask questions about research and clinical application.
2. Participants will be able to describe how family members of trauma survivors experience secondary trauma and how this can affect relationships between the survivor and family members.
3. Participants will be able to define a specific pattern of attachment and discuss how it may influence outcome for adult survivors of childhood trauma.

**Location:** Beach Room (7<sup>th</sup> floor)

## POSTER ABSTRACTS

Posters will be on display in the Conference Foyer over the duration in the conference

**The Association between PTSD Symptoms and Memory in Violent Offenders** by Kristine Armstrong, Barry Cooper, & John Yuille

Although the association between symptoms of Post Traumatic Stress Disorder (PTSD) and autobiographical memory has been examined in war veterans and victims of trauma, little research attention has been devoted to this issue in offenders of violent crime. As part of

a larger study investigating the variables associated with eyewitness recall, 150 male Canadian violent offenders were interviewed about their memories for past acts of perpetrated violence (both instrumental and reactive acts of violence) and experiences of trauma. After each memory was exhausted for detail with the Step-Wise investigative interview protocol (Yuille, 1990), the Memory Characteristics Questionnaire (Johnson, Foley, Suengas, & Raye, 1988) was used to assess for memorial vividness and detail and the Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979) was utilized to assess for PTSD symptoms in relation to each memory. Preliminary analyses suggest that PTSD symptoms are significantly correlated with better memory for acts of perpetrated reactive violence ( $r = .18, p < .05$ ) and experiences of trauma ( $r = .23, p < .01$ ) but not for perpetrated acts of instrumental violence ( $r = .19, p > .05$ ). Future analyses will, in part, focus on the association between PTSD symptom subscale (i.e., avoidance and intrusion symptoms) scores and memory. The results will be discussed in terms of implications for the criminal justice system.

**Socially Phobic Adults Show Hyposecretion of Salivary Cortisol at Rest and in Response to a Social Stress Test** by Elliott A. Beaton, Louis A. Schmidt, Andrea R. Asbaugh, Martin M. Antony, Randi E. McCabe, & Jay Schulkin

A number of recent studies have noted elevated baseline cortisol levels and exaggerated cortisol reactivity in response to social challenge in normal populations of shy and socially anxious adults and children. We compared salivary cortisol responses in a group of university students, some of whom met DSV-IV criteria for social phobia. Results revealed that socially phobic adults demonstrated relatively significantly lower baseline levels and significantly less salivary cortisol reactivity to a social stress test compared with healthy adults. These seemingly paradoxical findings are similar to the pattern of hypoactivation of the hypothalamic-pituitary-adrenal (HPA) axis observed in PTSD patients, rape victims, and other survivors of traumatic events. We speculate that hypoactivation of the HPA axis in these social phobics could reflect a homeostatic down-regulation of the HPA system in response to a life history of chronic shyness and social anxiety.

**An Investigation of the Impact of Chronic Work Stress and Critical Incidents on Correctional Staff and the Factors that Moderate it**

By Marlo Gal, PhD

Work related stress is increasingly recognized as one of the most serious occupational health hazards (Cummins, 1990; Spielberger & Reheiser, 1995). The effects of job stress include health-related problems, absenteeism, decreases in productivity, long-term disability, burnout and high staff turn-over rates. It has been suggested that the correctional environment is one of the most stressful work environments due to the inclusion of exposure to critical incident stress in conjunction with normal work stress. While the impact of work stress has been studied in the correctional environment (e.g, Lariviere, 2000, Milson, 1999; Rosine, 1992), the scope has been limited to generic work stress measures that do not reflect the nature of the stress that individuals working in a correctional environment are exposed to. The present study explored the types of

stressors that correctional staff is exposed to, the perceived impact that these stressors have, and the psychological and physiological impact of being exposed to these stressors. Overall, correctional staff are exposed to a number of stressors that included both workplace systemic stress, offender generated violent incidents and critical incidents. Exposure to these stressors has a negative impact on both the mental and physical health of staff which is reflected in the outcome measures. Psychological well being and social support are found to buffer the effects of stress, particularly under conditions of high stress.

**Therapeutic Boundary Dilemmas with Survivors of Childhood Sexual Abuse** by Kim Harper, PhD, RSW, & Carol A. Stalker, PhD, RSW

Adult childhood sexual abuse survivors present relentless boundary quandaries for therapists; this phenomenon appears to be related to the violation of physical, emotional, intellectual, and spiritual boundaries that is inherent in the experience of child sexual abuse. Many boundary decisions can lead to situations where survivors and therapists replay feelings connected to the original trauma. Although some authors and organizations have attempted to list a set of rules for therapists to follow, with respect to nonsexual boundary issues, rules are not always helpful because the decisions are made through an interactive process between the client and therapist. Changes in boundaries are ubiquitous because decisions are based on what is momentarily occurring in the relationship and therefore a set of "dos and don'ts" cannot be applied to all situations and are not always adequate in helping a therapist to make a quick decision. Survivors must know that their therapists can set limits, but mindful flexibility around some boundaries can be helpful. This workshop, based on qualitative research with survivors and therapists who work with them, will address some of the boundary dilemmas that therapists regularly face. Use of touch in therapy, contact between sessions, dual relationships, and therapist self-disclosure are some of the boundary issues that will be addressed with particular focus on boundary management when survivors are distraught and the ability of survivors and therapists to exercise choice with respect to decision-making. Themes identified in the research study that can inform boundary decision-making will be discussed. The workshop will be interactive and will include case scenarios and small group discussion.

**Catastrophic School Shooting and Recovery Model, Including Treatment Methods and Approaches** by Karin Jordan, PhD

This presentation will focus on a catastrophic school shooting trauma and recovery model. Catastrophic school shootings are different from milder forms of school violence, in that they generally involve multiple fatalities and injuries, with many more exposed to the threat of death or injury. Other factors include the death and/or injury of loved ones and the viewing of grotesque sights. A catastrophic school shooting is a time of crisis that can best be described as a period of psychological disequilibria in the victims' and their families' behavior, as well as cognitive and psychological effects. The issue of resilience and stress buffers in relation to the model will also be addressed. The model focuses on the stages and the behavioral, cognitive, and psychological responses and needs, as well as treatment approaches and techniques. Emphasis is placed on the special needs of victims, victims'

families and family subsystems (i.e. parental or sibling).

**The Color- Coded Trauma Genogram** by Karin Jordan, PhD,

This poster session will demonstrate how to use a color-coded trauma genogram with trauma survivors. This joining and information-gathering tool was effectively used with 55 families with histories of domestic violence, child abuse, etc. Therapists consistently reported that it helped them gain a better understanding of how the traumatic event impacted the family's: (1) individual interactions; (2) intergenerational structure and function; and (3) relational patterns, strengths, and vulnerabilities.

**Vicariously Witnessing Trauma: Implications for the Viewing Public**

Patrice Keats

When standing before the historical evidence of a massive trauma such as the Holocaust, people witness trauma through photographs, artistic images, survivor stories, and physical remnants or artifacts. From this evidence, the mind creates a semblance of this historical event. The effect of this imaginative reconstruction involves a powerful experience, where people believe that they know something very deeply about the event by living through the experience of another. This phenomenon is the vicarious witnessing experience. This research project explored the personal impact on participants of vicariously witnessing trauma through representations of traumatic events when visiting the concentration camps in Germany and Poland. The findings offer an understanding of the meaning and impact that participants derived from the vicarious witnessing act. Each participant offered three types of narrative perspectives including written (travel journals), spoken (interview texts), and visual texts (photographs). The participants constructed these various texts before, during, and after visiting four European concentration camps. In analyzing these texts, I utilized two types of narrative analyses, interpretive readings, and narrative instances. The analysis showed that participants filtered their vicarious witnessing experience through personal and cultural frameworks, struggled with tensions between perceptual and imaginative perspectives, felt transposed into the place of the traumatized other, experienced emotional, physical and spiritual vulnerability, developed personal and collective coping strategies, depended on participant group relationships for support and debriefing, and engaged in social action evoked by the vicarious witnessing experience. Implications of this study include a strong correlation between re-experiencing phenomenon (e.g., flashbacks) and participant's description of the witnessing after-image; an important aspect of coping related to safe social connections within a group; and perceptual-cognitive tensions that may be developed as a preventative measure against secondary trauma in frontline workers.

**The Impact of Trauma on Emotion Regulation and Emotion Processing in a Child**

**Inpatient Population** by Patricia K. Kerig, Holli Sink, Kurt Stellwagen, Andy Williams, & Jill McFee

Advancement in the field of developmental psychopathology requires that we identify the underlying mechanisms through which trauma exerts its effects on children (Kerig & Wenar, 2004). A key construct that has been identified in childhood traumatology is emotional

competence, which comprises three distinct functions: emotion appraisal, recognition, and regulation (Bohnert et al., 2003). Separate bodies of research have linked child abuse to emotion dysregulation (Cicchetti et al., 1995), distorted appraisals (Dodge et al., 1995), and emotion recognition deficits (Pollak & Sinha, 2003). However, little research to date has looked at these multiple dimensions of emotional functional in tandem, nor has research yet articulated the specific links between these dimensions of emotional development and childhood symptomatology. To address these questions, 65 youth aged 8 to 15 were recruited from the inpatient psychiatric unit of a state hospital. Social workers completed a child abuse history scale (McGee et al., 1990) which assessed diverse forms of maltreatment, including physical, sexual, and emotional abuse; neglect; and exposure to domestic violence. Youth were administered tasks assessing emotion recognition (Buitelaar et al., 1999), emotion appraisal (Sutton et al., 1999) and PTSD symptoms (Briere, 1992). Caregivers provided ratings of emotion regulation/dysregulation (Shields & Cicchetti, 1998). Results showed modest correlations among the different measures of emotional competence (all  $r < .30$ ), suggesting that they are related but distinct constructs. Structural equation modeling showed that the effects of child abuse on PTSD symptoms were mediated by emotion dysregulation and were moderated by the effects of poor emotion recognition.

#### **Prazosin effects on specific symptoms in Chronic Combat Trauma PTSD** by Michele Klevens

Prazosin is a generically available brain active alpha-1 adrenergic antagonist. We recently reported a placebo-controlled crossover study demonstrating that prazosin substantially and effectively reduces trauma-related nightmares, sleep disturbance and overall PTSD severity in Vietnam War combat veterans with chronic PTSD (*Am J Psychiatry* 2003;160:371-373). Here we report the effects of prazosin on specific PTSD symptoms as described by the Clinician Administered PTSD Scale (CAPS). Ten Vietnam combat veterans with chronic PTSD and frequent severe treatment resistant trauma related nightmares (CAPS recurrent distressing dream item score  $\geq 6$ ) participated in a double-blind, placebo-controlled crossover study. They were randomized to prazosin or placebo for a three-week drug titration period followed by six weeks on maximum effective dose. Following a two-week washout period, they were then "crossed over" to the other medication (prazosin or placebo). Maintenance psychotropic drugs were kept constant. Change scores were compared between prazosin and placebo conditions by paired t test. Prazosin was significantly more effective than placebo on the following CAPS items: intrusive memories ( $p=0.03$ ); recurrent distressing dreams ( $p<0.001$ ); physiologic distress on exposure ( $p<0.01$ ); decreased interest ( $p=0.03$ ); restricted range of affect ( $p=0.03$ ); sleep disturbance ( $p=0.01$ ); irritability/anger ( $p=0.01$ ). Prazosin significantly reduces severity of multiple PTSD symptoms across the accepted cluster of PTSD symptoms.

#### **Project SUNRISE: Mobilization Program for Youth at risk/vulnerable of Afrodiasporic heritage**

Teresa Naseba Marsh, MA, RN, OCN; University of Toronto; Private practice

African Canadian and Caribbean youth (ACCY) in Toronto face many challenges related to immigration, drug use within their environment and a recent wave of murders (2 per month

from 2001-2003). The purpose of this project was to evaluate a pilot project of a novel intervention aimed at vulnerable / at risk ACCY designed to build skills necessary to prevent involvement in crime or victimization and enhance decision making and conflict resolution. The novel intervention involved 8 two-hour sessions for groups of ten youth and included instruction in yoga exercises as well as psycho-educational information on the Nguzo Saba, Ma'at, conflict resolution, life skills and assertiveness training. A questionnaire on demographics was completed at the beginning of the eight week sessions. In addition, a qualitative and quantitative structured questionnaire was administered at the beginning and the end of the eight weeks. Quantitative (Likert-type) responses were analysed using a Wilcoxon rank sum test/pooled T-test for comparing two independent populations. Of 94 enrolled, 61 youth successfully completed the intervention. Pre/Post test comparison showed completers reported being: more likely to stop and think before they make a decision ( $p > 0.0041$ ); more likely to feel that communication is essential to solve a conflict ( $p > 0.0307$ ); Slightly more likely to listen to others when in an argument ( $p > 0.0583$ ); slightly less likely to feel that physical action is essential to solve a conflict ( $p > 0.0592$ ). Participants also completed a manual, video and website describing their experiences in the project ([www.projectsunrise.com](http://www.projectsunrise.com)). This novel intervention deserves further evaluation.

### **Specialized In-patient Trauma Treatment for Adults Abused as Children: A Follow-up Study**

By Carol A. Stalker PhD, Sally E. Palmer PhD, David C. Wright MD, FRCPC,  
Robert Gebotys PhD, & Kim Harper PhD

**Purpose of the study:** to investigate outcome at discharge and follow-up for adults abused as children who completed a six-week inpatient program for traumatic stress recovery. **Method:** Beginning with 131 women and 29 men, participants were assessed at admission, discharge, and at three, six, and 12 months post-discharge on measures of global symptom severity, PTSD symptoms, and disrupted beliefs. Two wait-list groups ( $n = 42$  and  $n = 52$ ) were assessed at points in time corresponding to admission, discharge and three months post-discharge. Clinically significant change was calculated using Jacobson & Truax's (1991) criteria. Interviews were conducted with a sub-sample at 6 months follow-up. **Results:** Compared to admission, the mean scores on all outcome measures for the treatment group were improved at discharge ( $p = .001$ ), and at six ( $p = .001$ ) and 12 months follow-up ( $p = .001$ ). Compared to wait list groups, mean scores for the treatment group were significantly improved at discharge ( $p = .025$ ); at three months post-discharge the scores for the treatment group were not different from those of the wait list group because of the deterioration in the treatment group at three months follow-up. Almost all participants experienced the program as helpful. However, only 32% to 45%, depending on outcome measure, met stringent criteria for clinically significant change at 12 months post discharge. **Conclusions:** Although most adults with histories of severe child abuse experience specialized inpatient trauma treatment as helpful, and report positive change on quantitative measures, over 50% do not meet stringent criteria for clinically significant change one year later.

### **Reference:**

Jacobson, N.S. & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting & Clinical Psychology*, 59, 12-19.

**Anxiety sensitivity and its implications for understanding and treating PTSD** by Jaye Wald, Ph.D.

Empirically-supported psychosocial treatments for posttraumatic stress disorder (PTSD) all entail some form of trauma-related exposure therapy (e.g., imaginal and in vivo exposure to distressing, but non-threatening trauma-related stimuli). Although these treatments are often useful, none are effective for all patients. Even those who respond are often left with residual symptoms. A better understanding of these causes may lead to more effective treatments. This presentation will review the nascent but steadily growing research on the role of anxiety sensitivity (fear of arousal-related sensations) in PTSD. Available evidence suggests that anxiety sensitivity may play an important role in amplifying PTSD symptoms. Preliminary results from a pilot study suggest that interoceptive exposure - an intervention that directly targets anxiety sensitivity - reduces PTSD symptoms and may be usefully combined with trauma-related exposure therapy. Using a case series design, 5 patients diagnosed with PTSD were recruited. These individuals received 12 weekly sessions of individual treatment consisting of 4 sessions of interoceptive exposure therapy, 4 sessions of imaginal exposure therapy, and 4 sessions of in vivo exposure therapy. Treatment outcome was assessed by the Clinician-Administered PTSD Scale (CAPS), and self-report measures of PTSD symptoms, anxiety sensitivity, depression, and generalized anxiety. At post-treatment assessment, there was a reduction on all measures for all but 1 patient. The results were maintained at the 1-month and 3-month follow-up assessments. These results suggest that interoceptive exposure therapy may be a promising intervention for treating PTSD. Treatment implications and directions for further research are discussed.

**Mediators of the Link between Childhood Sexual Abuse and Emotional Distress: A Critical Review** by Valerie E. Whiffen & Heather B. MacIntosh

A history of childhood sexual abuse (CSA) is a risk factor for adult emotional distress, including symptoms of depression, anxiety, dissociation, and post-traumatic stress. However, CSA likely is associated with adult distress indirectly, through an impact on mediating variables. The goals of our review are to determine which variables are potential mediators of this link, and to provide methodological guidelines for future research. We reviewed 19 unique studies that assessed mediators of the link between CSA or maltreatment and adult emotional distress, using the procedure recommended by Baron and Kenny (1986). The evidence for mediation is strongest for shame or self-blame, interpersonal difficulties including attachment insecurity, and the use of avoidant strategies to cope with the CSA. Thus, psychological treatments focused on softening self-blame, addressing interpersonal difficulties, enhancing attachment security, and promoting the use of emotional expression instead of avoidance to cope with the abuse will be effective in reducing the emotional distress associated with CSA. However, we identified a

number of methodological and conceptual problems with the existing research. Specifically, researchers do not always use accepted procedures for determining mediation, and there is confusion about the difference between mediators and proxy variables. Researchers need to have a better understanding of causal and non-causal risk factors, and of the ways in which these risk factors interact with each other. Models explaining emotional distress also need to consider moderating as well as mediating variables.

## Presenter BioSketches

### Plenary Faculty

**Chris R. Brewin**, Ph.D. is professor of clinical psychology at the Subdepartment of Clinical and Health Psychology, University College London. He is also an honorary consultant clinical psychologist with the the Camden & Islington Mental Health and Social Care Trust and he specializes in the treatment of PTSD at the Traumatic Stress Clinic. His general area of interest is in cognitive processes underlying psychopathological states, and his current research is on memory processes in traumatized individuals, including the processes underlying forgetting and memory recovery. Among recently completed funded projects are a study of intrusive memories in PTSD and depression, a randomized controlled trial of psychological debriefing for victims of violent crime, and a survey of clinical psychologists' experiences of clients in their practice with recovered memories. He is a Fellow of the British Psychological Society, and a member of the European Society for Traumatic Stress Studies, the American Psychological Association, and the British Association for Behavioural and Cognitive Psychotherapy. He has recently been appointed associate editor of the Journal of Traumatic Stress.

Professor **Alexander C. McFarlane**, MB. BS. (Hons), MD., Dip. Psychother., FRANZCP is one of the leaders in the field of traumatic stress. He is currently the Head of the Department of Psychiatry at the University of Adelaide, based at The Queen Elizabeth Hospital. He is a recognized international expert in the field of post traumatic stress disorder and is a Past President of both the International Society for Traumatic Stress Studies and the Australasian Society for Traumatic Stress Studies. He is the recipient for the Robert Laufer Award for outstanding scientific achievement in the study of the effects of traumatic stress. Prof. McFarlane is currently the Senior Advisor in Psychiatry to the Australian Defence Force and the Australian Centre for Posttraumatic Mental Health. He is also an advisor to the Department of Veterans' Affairs on a scientific investigation of Gulf War Syndrome. He has acted as an advisor to many groups in post disaster situations, including the Kuwait Government, and the United Nations. He has lectured and run workshops in Europe, United States of America, Asia and South Africa. Apart from his interest in post traumatic stress disorder in relation to disaster victims, military personnel and other civilian accidents, he has broadened the relevance of this knowledge to the area of those suffering severe mental illness. His research has focused on the epidemiology and longitudinal course of PTSD as well as the neuroimaging of the cognitive deficits in this disorder. He has published over 160 articles in various refereed journals and has co-edited three books. He is a member of several international advisory boards in the field of traumatic stress. He has also been involved in a medico legal cases in a number of jurisdictions in Australia and the United Kingdom on matters relating to traumatic stress. He has appeared on radio and television, including the Four Corners, Quantum and Catalyst programs to discuss matters relating to post traumatic stress disorder.

**Rachel Yehuda**, Ph.D. is Professor of Psychiatry at the Mount Sinai School of Medicine, and is Director of the Division of Traumatic Stress Studies at the Mount Sinai School of Medicine and Bronx Veterans Affairs Medical Center. She is an active researcher in the field of posttraumatic stress and has authored more than 200 articles and edited several books on this topic. She has numerous professional memberships such as the American College of Neuropsychopharmacology and International Society for Traumatic Stress, and has served on many scientific advisory and journal editorial boards. Dr. Yehuda served as a delegate for the White House conference on Mental Health in 1999 and was recognized in the Congressional Record for her work with Holocaust survivors. Dr. Yehuda is one of four Executive Directors on the New York Times Consortium for Trauma Treatment, founded in response to the World Trade Center Disaster in New York. Dr. Yehuda received her Ph.D in Psychology and Neurochemistry and her MS in Biological Psychology from the University of Massachusetts at Amherst and completed her postdoctoral training in Biological Psychiatry in the Psychiatry Department at Yale Medical School.

## Workshop Faculty

**Cheryl Bell-Gadsby**, M.A., R.C.C., M.F.C.C., has over eighteen years experience in the US and Canada as a therapist, clinical supervisor and educator. She has specific expertise in issues of trauma, family violence, sexual exploitation and abuse, child and adolescent development, and hypnotherapy with children, adolescents and adults. Cheryl has recently co-authored *Reclaiming Herstory: Ericksonian Solution-Focused Therapy for Sexual Abuse*. Cheryl is a Program Coordinator at the Justice Institute of British Columbia, Canada where she is engaged in the development and delivery of training and curriculum in the areas of counseling, abuse, trauma and violence.

**Lyndra J. Bills**, MD is a board certified psychiatrist who completed an internal medicine/psychiatry residency and a psychotraumatology fellowship at West Virginia University. She is currently the medical director for behavioral health services of Lancaster General Medical Group in Lancaster, PA. She has been one of the developers of the Sanctuary Model of trauma treatment and continues to teach and train in the use of the Sanctuary Model. Her clinical interests include psychopharmacology, trauma treatment especially the nonverbal therapies like Trauma Art, creating trauma-based therapeutic milieus and the use of videotaping in therapy. She was one of the original developers of the Trauma Art technique during her psychiatry residency. For fun, she is a horse fanatic...enjoys riding horses for fun and also training them.

**Charles R. Brasfield**, MD, PhD, FRCPC is a Clinical Associate Professor in the Department of Psychiatry at UBC where he supervises psychology residents in the Health Psychology Clinic. His training is in clinical psychology and psychiatry and he has a special interest in First Nations mental health. For more than a decade he has provided outreach psychiatric services to First Nations communities on the Central Coast and in Northern BC, particularly the Heiltsuk community of Waglisla. His private practice is in North Vancouver, BC. Many of the patients he supervises at UBC or sees in either his private practice or psychiatric outreach have a trauma history.

**Susan Brock**, PhD is a clinical psychologist with Chartier Arnold Brock and Associates, a group private practice in Saskatoon, Saskatchewan where she specializes in the assessment and treatment of post-traumatic stress disorder with particular interest in military/veteran and police populations. She received a Ph.D. in clinical psychology from the University of Saskatchewan and completed her doctoral internship at the National Center for Post-traumatic Stress Disorder (PTSD) at the Boston Veteran's Administration Medical Center. She also participated with the People to People Ambassador Program on Post-traumatic Stress Disorder, a professional delegation to South Africa, comprised of therapists, researchers and educators from around the world, all sharing a common professional interest in trauma. The delegation met with a variety of organizations in order to exchange knowledge

regarding Post Traumatic Stress within the community as a whole. The trip ended with the delegates participating in the inaugural South African Conference on Post-Traumatic Stress: Working Toward Solutions, sponsored by The Center for the Study of Violence and Reconciliation in Johannesburg.

**Gloria Cardey** MSW RSW is a Social Worker with the Program for Traumatic Stress Recovery at Homewood Health Centre in Ontario. Gloria has an extensive clinical background in addiction recovery and, for the past five years, has been providing group, EMDR, individual and family therapy for clients in the Program for Traumatic Stress Recovery. With a social work colleague she actively initiated and developed a two-day workshop to address the needs of friends and family members of program participants.

**Natalie Clark**, M.S.W., R.S.W. has extensive experience as a therapist, clinical supervisor and educator specializing in issues of child abuse, trauma, sexual abuse and exploitation and adolescent development. She currently works with youth in a variety of settings including individual and group work in schools, youth centers, and youth clinics. Natalie is a Program Coordinator at the Justice Institute of British Columbia, Canada where she is engaged in the development and delivery of training and curriculum in the areas of counseling, abuse, trauma and violence.

**Peggy Clarkson**, MA, ATR, RCC, RCAT is a registered art therapist, registered clinical counselor and artist. She attained her Bachelor's degree in psychology and fine arts from the University of BC and her Masters degree from Concordia U in Montreal. Peggy has lived in both Haida Gwaii and Bella Bella, BC, where she worked with the Haida and Heiltsuk Nations. This therapeutic work involved providing services in small isolated, rural Aboriginal communities. Her most recent position was located at RW Large Memorial Hospital as the clinical therapist in the relatively new (now no longer functioning) Bella Bella Clinical Psychiatry Program. Peggy provided complementary treatment (both art and verbal psychotherapy) to the medical team interventions, and outreach psychiatry provided to the community. Peggy recently moved from Bella Bella, BC to North Vancouver, BC. She is a member of the Canadian, American and BC Art Therapy Associations, the National Expressive Therapies Association and the BC Association of Clinical Counsellors

**Anne Dietrich**, PhD has several years' experience working with individuals who suffer from the effects of single-incident and chronic trauma. Her professional background includes crisis intervention, individual, couples, family and group psychotherapy, research, and teaching. Anne is the recipient of several graduate fellowships, including several UBC graduate fellowships and a 3-year doctoral fellowship from the Social Sciences and Humanities Research Council of Canada (SSHRC) to study Complex Post Traumatic Stress Disorder, a Green Cross Foundation Fellowship, and an IODE War Memorial Scholarship. She is a recipient of the International Society for Traumatic Stress Studies Student Research Award. Anne is a member of the Canadian Psychological Association; International Society for Traumatic Stress Studies; International Society for the Study of Dissociation; and American Psychological Association. Anne has served as the Treasurer and is currently President of the Canadian Society for the Study of Trauma and Dissociation, and sits on various ISSD committees.

**Monique Giard** is a doctoral candidate at the Centre for Cross-Faculty Inquiry in Education (CCFI), University of British Columbia. She crosses the Faculties of Education and of Counselling Psychology. She is a certified counsellor and works as a counsellor with the Fraser Health Authority (Rehabilitation for Historical Abuse Program). She has devoted most of her work to youth suicide prevention, intervention and postvention through performative interventions in addition to individual counselling practices. She is a member of the Canadian Association for Suicide Prevention (CASP) and an active member of Survivors of Suicide Advocates. Her suicide prevention interests lead her to see

the link between transgenerational and historical trauma and the high rate of suicide with First Nations, Inuit, and Métis peoples in Canada. As a performance artist, she uses video making and storytelling as her performative tool-and-result methodology helping youth grow developmentally through a process of understanding and accepting, in an activist sense, their capacity to create.

Lieutenant Colonel **Stéphane Grenier** joined the Canadian Forces in 1983. He served with the 12 Régiment Blindé du Canada in Valcartier, Québec as an Armored Officer and as a Leadership Instructor at the Canadian Force Officer Training School in Chilliwack British Columbia. He Became a Public Affairs Officer in 1992 and was employed in various functions such as: Editor of Sentinelle Magazine, spokesman for the Canadian Forces with the National Defence Media Liaison Office. In 1994 he was deployed to Rwanda for 10 months as the spokesman for the United Nations in Rwanda. Following his return he became team leader and producer in the Canadian Forces Electronic News Gathering team and was deployed for much shorter period of time in many regions of the Globe including : Cambodia, Kuwait, the Arabian Gulf on ship, Africa, Lebanon and Haiti to name a few. In 1998, he was appointed as the Communications Director for the Army Headquarters in the Ontario Region. Upon return from Rwanda, Lieutenant Colonel Grenier requested medical help in 1995 and was misdiagnosed. He was later diagnosed in 1997 with PTSD but not told of his diagnosis and no treatment was offered to him. After his third attempt for medical help, Lieutenant Colonel Grenier was diagnosed for a second time with PTSD in 1999 and has been in therapy ever since. Along the way, Lieutenant Colonel Grenier took a personal interest in the way the Canadian Forces was dealing with operational stress injuries and began research on the issue and developed various concepts he felt could help soldiers deal with what they had lived through and experienced while on operations abroad. As a result of his own experiences at dealing with trauma and years of research and consultation with various veterans and clinicians, he created and put forward the Operational Stress Injury Social Support (OSISS) Project concept. In May 2001 the project was accepted and he was appointed as the Project Manager. Lieutenant Colonel Grenier is still married to his wife Julie who remains to this day a solid lifeline and source of support. Julie and Stéphane have two children, David and Véronique.

Major **Rakesh Jetly**, MD (FRCPC) has been with the Canadian Forces (CF) since 1989. He received his medical degree from the University of Toronto in 1991. Between 1991 and 1996 he served as a General Duty Medical Officer with the CF within Canada and deployments to the Middle East (1993-1994) and Rwanda (1994). He returned to Toronto to complete his Post Graduate training in Psychiatry in 1996, after which he was posted into his present position in Halifax. Dr Jetly has presented throughout Canada and the US on topics including PTSD and dissociation in Canadian peacekeepers. He is involved in various research projects studying prospectively the impact of peacekeeping missions, dissociative experiences of soldiers with PTSD, as well as the impact of PTSD on spouses.

**Lori S. Katz**, Ph.D. is a licensed clinical psychologist . She earned her bachelor's degree at the University of California, Berkeley, and her master's and doctorate degrees at the University of Massachusetts, Amherst. Since 1991, she has been a staff psychologist at a VA Medical Center. She is the Military Sexual Trauma coordinator for the facility and has received numerous awards for her work in educating, assessing, and treating trauma. She recently published the book, *Holographic Reprocessing: A cognitive experiential psychotherapy for the treatment of trauma*, Brunner-Routledge: New York.

**Eva Knell**, MD (CCFP, FCFP) graduated from UBC Medical School in 1985 and completed her Family Practice Residency at the Holy Cross Hospital (University of Calgary) in 1987. She has worked in Alberta and British Columbia, both in the city and rural locations. She has long been active in teaching. She is currently the Associate Head for the UBC Department of Family Practice as well as the Site Faculty for Behavioural Medicine at the St. Paul's Hospital Family Practice Residency Program. In the latter position she leads a group of family physicians and counselling psychologists in developing and

delivering a program of doctor-patient communication competencies. She has a strong interest in the relationship between psychological trauma and how that is expressed in medical situations. In addition to completing a National Family Medicine Fellowship through the University of Toronto in 1995, she was named a Harvard- Macy Scholar in 2003.

**Dr. Catherine Koverola** is a clinical psychologist with over 20 years of experience in the field of trauma as a clinician, researcher, and educator. Her areas of expertise include: vicarious trauma, assessment & treatment of trauma, child abuse & intra familial homicide, domestic violence, intergenerational violence, forensic psychology, ethics of rural and cross cultural practice. Dr. Koverola's work has been published in numerous peer-reviewed journals. She frequently presents at local, national and international conferences and conducts training seminars on topics that include: assessment and treatment of traumatized children, forensic assessment of child victims, post traumatic stress disorder, and vicarious trauma among mental health practitioners. Dr. Koverola's clinical and research experience includes working with indigenous peoples in isolated communities throughout Canada and Alaska. She also has extensive experience in the inner city with new immigrant and refugee families from Mexico and Central America as well as African American families who have experienced multiple forms of violence and trauma. Dr. Koverola is Professor of Psychology and Director of the Community Psychology Graduate Program at the University of Alaska, Fairbanks.

**Ruth Lanius, MD (FRCPC), PhD.** graduated from the University of British Columbia with a combined M.D. and Ph.D. degree in Neuroscience in 1996. She continued her training at the University of Western Ontario where she completed her residency in psychiatry in 2000. Since the summer of 2000, she has been an assistant professor in the Department of Psychiatry at the University of Western Ontario. She established and directs the Traumatic Stress Service, a program that specializes in the treatment and research of Posttraumatic Stress Disorder (PTSD) and related comorbid disorders. Her research interests focus on studying the neural correlates of PTSD using neuroimaging (functional magnetic resonance imaging) and treatment outcome research examining various pharmacological and psychotherapeutic methods. Her research is currently funded by the Canadian Institutes of Health Research, the Ontario Mental Health Foundation, and the Department of National Defense of Canada.

**Rod McCormick, PhD.** is a member of the Mohawk Nation who works as a Psychologist and Counselling Psychology professor at the University of British Columbia. In addition to receiving Hampton and SSHRCC research grants to investigate Aboriginal healing and counselling, Dr. McCormick is also the Principal Investigator of a multi-million dollar Canadian Institutes of Health Research Grant to develop greater capacity in Aboriginal Health Research. Dr. McCormick has an active consulting practice and works as a clinical consultant to several Aboriginal healing programs and treatment centres who specialize in the treatment of survivors of sexual abuse.

**Greg Passey, MD (FRCPC)** specializes in trauma psychiatry. From 1993 to 1995, Dr. Passey was involved in research on the epidemiology of posttraumatic stress disorder and depression in Canadian Forces Peacekeepers serving in the former Yugoslavia. In 1995, he received the Laughlin Fellowship from the American College of Psychiatrists for research and leadership in the field of Psychological Consequences of UN Peacekeeping. He retired from the military in September 2000 after 22 years of service and currently works in private practice and in the Outpatient Psychiatry Program at the Vancouver Hospital and Health Sciences Centre. He has been a presenter/speaker on posttraumatic stress disorder at numerous conferences and is actively involved in teaching professionals and the public about this disorder.

**Vivienne C. Rowan, Ph.D., C.Psych.** is the founder and Clinical Director of the Assiniboine Psychological Group and cofounder of the National Trauma Recovery and Rehabilitation Clinic. She provides

psychological services with a multidisciplinary team of mental and physical health specialists. Dr. Rowan received her Master's degree in Experimental and Applied Behavior Analysis and her Ph.D. in Clinical Psychology from the University of Manitoba and the Medical College of Pennsylvania. She specializes in Cognitive Behavior Therapy of stress and anxiety disorders with related psychological problems. Her current focus is on the assessment and treatment of Acute and Traumatic Disorders and disability management.

**Olivia Scalzo**, PhD is a registered psychologist in Vancouver. Her work with women survivors of sexual abuse and assault began over twenty years ago. She has worked in a variety of settings including university counselling services and a women's correctional facility. Dr. Scalzo maintains a private practice with a focus on psychotherapy for trauma, abuse, depression, anxiety and women's issues relating to pregnancy, childbirth and postpartum adjustment. She also provides clinical supervision to counsellors in several community agencies and women's centres.

**Carol A. Stalker PhD, RSW** is Associate Professor in the Faculty of Social Work, Wilfrid Laurier University (WLU). In 1998, she was the principal investigator of a SSHRC-funded study of factors affecting maintenance of treatment gains following inpatient trauma treatment for adult survivors of child abuse. She has also been involved in participatory action research to increase the knowledge and sensitivity of health professionals to the needs of adult survivors of child sexual abuse. Carol is currently involved in the study of employees' experiences in child welfare settings, and the experiences of South Asian families who have received child welfare services. Prior to teaching at WLU, she provided social work services to clients of the outpatient psychiatry department at the London (Ontario) Health Sciences Centre. During this period, she worked both individually and in groups with women survivors of child sexual abuse. She teaches courses in clinical social work practice, and has a private practice in Kitchener, Ontario.

**Gillian Templeton** BSc, BHSc, OT Reg (On) is the Program Coordinator for the Program for Traumatic Stress Recovery at Homewood Health Centre in Ontario. In response to needs identified by adult survivors of childhood trauma Gillian Templeton and supportive colleagues initiated development of Canada's only inpatient program for both civilian and military survivors. Since the program opened in 1993, she has continued to promote program and team growth via client feedback, education, teambuilding and research activities. She is clinically active in all aspects of program delivery: assessment; treatment, including a workshop for family and friends; discharge planning; and monitoring of the therapeutic community milieu. She actively supports the education of health care students via clinical placements and is a professional associate of McMaster University, providing guest lectures in the School of Occupational Therapy.

**Wahan Wanis**, MD, (FRCPC) is a psychiatrist working in Private Practice. He is an Associate Clinical Professor at UBC. He has worked extensively with PTSD patients and lectures on this subject to Psychiatry residents. He is also the Director of Medical Education for the Forensic Psychiatric Services Commission of BC.

**Valerie E. Whiffen**, PhD, C.Psych. is Professor of Psychology at the University of Ottawa. She has received several research grants related to trauma and childhood sexual abuse, and has written extensively in the area of trauma and childhood sexual abuse, including mood disorders, marital intimacy, gender differences, and attachment processes in couple and family therapy.

**Sandra Wieland**, Ph.D., R.Psych., has a private practice in Victoria, B.C. where she works with children, adolescents and adults who have experienced neglect and/or abuse. She was previously director of the Centre for Treatment of Sexual Abuse and Childhood Trauma in Ottawa, Ontario. Sandra has published 2 books for therapists on working with children who have been sexually abused (Sage

Publications) and is presently working on a book for foster and adoptive parents of children who have been traumatized. Sandra has presented workshops for therapists across Canada and the United States and in Europe. She has also presented workshops and training for foster and adoptive parents.

**Lyn Williams- Keeler**, M.A., BCETS, OACCPP is a certified psychotherapist and board-certified expert in traumatic stress. She is in private practice and conducts individual and marital therapy in the area of trauma. She also is an instructor in the Trauma and Addictions program at Algonquin College. Lyn has presented internationally in the area of trauma, and has also published several articles and book chapters focusing on PTSD

## **Poster Presenters**

**Martin M. Antony**, Anxiety and Treatment Research Centre, Hamilton; Dept. of Psychiatry & Behavioral Neuroscience, McMaster University

**Kristine K. Armstrong**, Department of Psychology, University of British Columbia

**Andrea R. Asbaugh**, Department of Psychology, McMaster University

**Elliott A. Beaton**, Department of Psychology, McMaster University

**Barry Cooper**, Department of Psychology, University of BC

**Marlo Gal**, PhD, Department of Psychology, Correctional Service of Canada, Pacific region

**Robert Gebotys** PhD,

**Kim Harper PhD, RSW**, School of Social Work, University of Windsor

**Karin Jordan**, PhD, Sherwood Oregon

**Patrice A. Keats**, Counselling Services, University of British Columbia.

**Patricia K. Kerig, Ph.D.**, Department of Psychology, University of North Carolina at Chapel Hill.

**Michele Klevens**, University of Washington, VA Puget Sound Healthcare

**Heather MacIntosh**, Department of Psychology, University of Ottawa

**Teresa Naseba Marsh** MA, RN, OCN, Addiction Psychiatry Program, University of Toronto; private practice

**Jill McFee**, Department of Psychology, University of North Carolina at Chapel Hill

**Randi E. McCabe**, Anxiety and Treatment Research Centre, Hamilton; Dept. of Psychiatry & Behavioral Neuroscience, McMaster University

**Sally E. Palmer** PhD

**Louis A. Schmidt**, Department of Psychology, McMaster University

**Jay Schulkin**, National Institutes of Mental Health, NIH

**Holli Sink**, Department of Psychology, University of North Carolina at Chapel Hill

**Carol A. Stalker PhD, RSW**, Faculty of Social Work, Wilfrid Laurier University.

**Kurt Stellwagen, M.A.**, School Psychology, University of North Carolina at Chapel Hill.

**Steven Taylor**, Ph.D., Department of Psychiatry, University of BC

**Jaye Wald**, Ph.D., Department of Psychiatry, University of BC

**Andy Williams, B.A.**, Children's Psychiatric Institute of John Umstead Hospital

**David C. Wright MD, FRCPC**, Homewood Health Centre, Ontario

**John Yuille**, Ph.D., Department of Psychology, University of BC

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