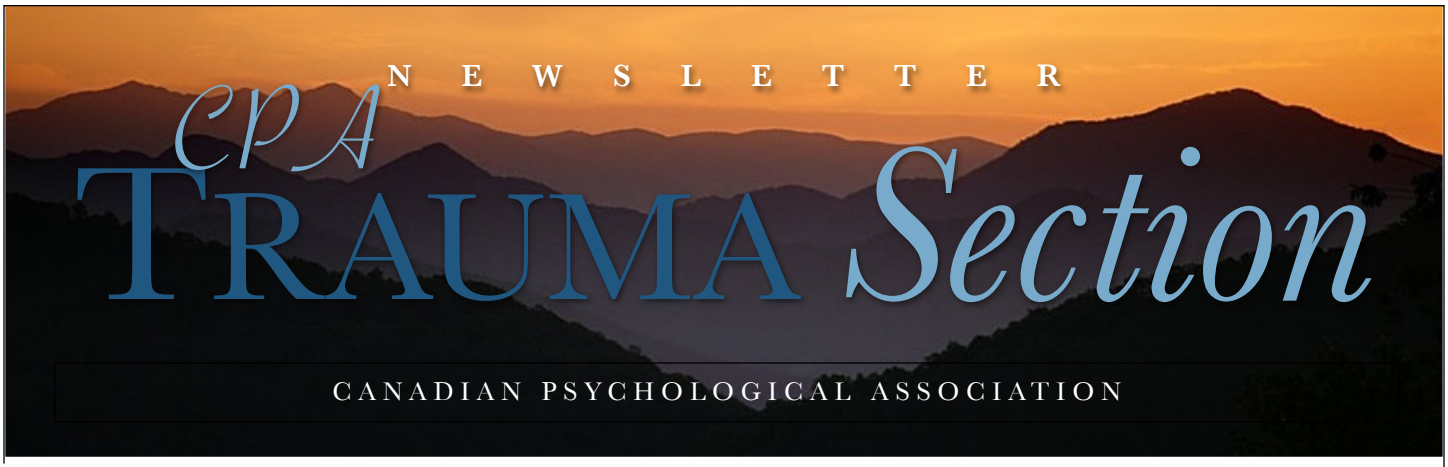

CPA TRAUMA Section NEWSLETTER

CANADIAN PSYCHOLOGICAL ASSOCIATION

Spring 2013
In This Issue:

Message from the Chair

There have been a number of significant developments since the last newsletter. First and foremost, I regret to tell you that Dr. Sandra Paivio has stepped down from the chair-elect position. We appreciate her participation in the TSS executive and thank her for her contribution.

We are grateful that Dr. Wendy Rogers agreed to assume the position of chair-elect. Dr. Rogers is a clinical psychologist who works at CFB Gagetown with active-duty military members, providing diagnostic assessment and treatment of mood and anxiety disorders and other comorbid Axis I and Axis II conditions. She has a particular interest in the assessment and treatment of combat-related Post-Traumatic Stress Disorder. We are delighted to have her join the TSS executive.

As you know, the CPA convention is just around the corner. It will be held in historic and stunning Quebec City. This year's convention has much to offer our members. Dr. Candice Monson is a CPA Invited Speaker and will be giving her talk on "Reconceptualizing PTSD and Enhancing Treatment: Harnessing the Healing Power of Relationships." In this address, she will discuss her evidence-based treatment, Cognitive-Behavioral Conjoint Therapy for PTSD. Dr. Marylene Cloitre will give the Section Address and will speak on "Social Bonds, Emotion Regulation and Health through the Life Span." Dr. Cloitre will also give a half-day pre-conference workshop on her treatment model, Skills Training in Affective and Interpersonal Regulation (STAIR). STAIR is an evidence-based treatment that takes a sequenced approach to healing from trauma. We are also delighted that both of these esteemed practitioner/researchers have contributed an article to this issue!

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Other important developments include an "experiment in global collaboration" initiated by the International Society of Traumatic Stress Studies (ISTSS). Participants include ISTSS and its affiliate member societies, including our Traumatic Stress Section and affiliate societies representing Asia (Asian STSS), Europe (ESTSS), Germany (DeGPT), Japan (JSTSS), South America (SAPsi), and Africa. In 2010, ISTSS adopted a strategic plan to strengthen global relationships among ISTSS and its affiliate members and launched the Global Collaboration Experiment. The goal of the Global Collaboration Experiment is to "achieve greater impact by coming together to advance a trauma issue of shared global significance." The first meeting of this global consortium occurred at the 2011 ISTSS Conference and was attended by our immediate past chair, Paul Frewen. At this meeting, preliminary discussions about a global collaborative project were begun and the group began to generate a list of possible issues the consortium could address.

At the 2012 ISTSS Conference, the Global Collaboration met for the second time. I had the privilege of joining this dynamic group and can report on the progress that was made. The Global Collaboration agreed on the following focus for the collaboration---the impact of childhood abuse and neglect on adults, with two broad goals:

1. Collect and synthesize a core set of guidelines that can be customized for cultural sensitivities
2. Develop an App for worldwide distribution and cultural customization.

A small group of us was charged with envisioning the App prototype. Together with Paul Frewen and Justin Kenardy from Australia, we came up with a description of what the App should do. Essentially, the App will provide information on child abuse and neglect, tools for coping, as well as links to more information.

The Global Collaboration also agreed to apply to Grand Challenges Canada for a proof of concept grant. I took the lead on the grant application in collaboration with Gladys Mwiti from Kenya and Miranda Olf from the Netherlands. If we are successful and receive the funding, this will allow the Global Collaboration to develop the prototype and test it in Kenya. Once the App is developed, the Global Collaboration can apply for a much larger grant from Grand Challenges Canada so that it can be adapted for global distribution. As a part of the application, we were required to create a two-minute video so

that the public can vote on it. If you are interested in viewing the video to cast your vote, simply follow this link.
http://applications.grandchallenges.ca/en/viewVideo/28735E6AA6EA36B0409F8BD9

I will be representing TSS at the next Global Collaboration meeting in Bologna, Italy, where we will continue working on this broad issue and our specific goals. This meeting occurs the week before our CPA convention. I look forward to reporting on the outcome of that meeting at the Annual Section Meeting. As you can see, our section is playing a major role in this Global Collaboration, giving us the opportunity to make a difference in the lives of trauma survivors worldwide.

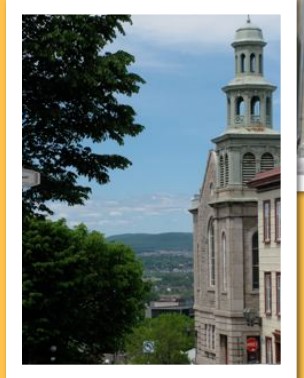
In this newsletter, you will see that the awards committee is ready to receive your nominations! Please consider nominating a worthy candidate for each of the award categories. You can also self-nominate so don't be shy!

Finally, please consider how you can get involved with our Traumatic Stress Section and don't hesitate to contact us with your ideas for how we can better serve you and the trauma community.

With best wishes,

Catherine Classen, PhD, CPsych
Chair, CPA-TSS

CPA Convention Highlights!



- *Candice Monson* - CPA Invited Speaker
- *Marylene Cloitre* - Section Speaker
- Half Day Workshop by *Marylene Cloitre*
- Humanitarian award to former NHL hockey player, *Theo Fleury*
- CPA sponsored symposium on child abuse with *Theo Fleury*, Catherine Classen and Paul Frewen
- TSS award announcements at Section meeting

Section Opportunities

Call for Nominations

The Traumatic Stress Section welcomes applications for the role of Chair Elect and Student Representative, with the elected members beginning their term in June 2013! Please consider nominating a fellow colleague, or consider applying yourself.

Self nominations are welcome!

Chair-Elect: The Chair-Elect should be available to carry out duties assigned by the Chair or requested by the Executive Committee or the general membership. Following a one year term, the Chair-Elect assumes the role of Chair, in which position she/he shall: i) Provide the overall supervision and administration of the affairs of the Section and ensure that all policies and actions approved by the general membership or by the Executive Committee are properly implemented; ii) Preside at general meetings of the Section and chair meetings of the Executive Committee; iii) Represent the Section on the CPA Committee on Sections, to the CPA Board of Directors, and to external bodies; and, iv) Provide an annual report to the members and to the CPA.

Student Representative: The student representative carries out duties as assigned by the Chair and Executive Committee. These duties are decided collaboratively according to the interests of the student and the needs of the section.

All nominations should be accompanied by a brief biography and CV of the candidate. Inclusion of a cover letter is also recommended. All materials must be received by April 19, 2013. Please send your nominations to the section Past-Chair, Dr. Paul Frewen, by email at pfrewen@uwo.ca.

Further, if you have any questions before applying or nominating a member, please contact Dr. Paul Frewen. A description of the roles and responsibility of each position as described in our section bylaws follows.

CPA Traumatic Stress Section
Annual Award Program

The Executive Committee of the Traumatic Stress Section has decided to inaugurate an annual awards program! An internal committee has been chosen to oversee the selection of candidates and consists of past section chairs: Drs. Paul Frewen (Chair), Alain Brunet, and Anne Dietrich. The committee also receives input from the section executive. We wish to add another committee member(s) from our section membership at large and encourage anyone interested in applying to contact Dr. Frewen at pfrewen@uwo.ca.

The CPA Traumatic Stress Section awards program will recognize psychologists and students in psychology who have demonstrated excellence in traumatic stress science and practice. Award recipients need not be section members at the time of their nomination/application, but will receive a one-year honorary membership to the Section if they are selected as a winner.

We invite nominations for our first annual awards program. Please consider nominating a suitable candidate and/or apply for an award yourself. Nominations must be received by May 1, 2013. Award recipients will be decided by committee vote. The awards ceremony will be held at the annual meeting in Quebec City! A description of the awards follows.

To all nominees – it is our hope that this program begins to formally recognize the excellent work that you do! Thank you!

Sincerely,

Paul Frewen, PhD, C.Psych.,
for the Awards Committee.

Self nominations welcomed!

CPA Traumatic Stress Psychologist of the Year

This award recognizes recent achievement within the science and practice of the psychology of traumatic stress by a psychologist(s) within the past 12 months. Applications by more than one psychologist, as a team of researchers and/or practitioners, will also be accepted.

CPA Traumatic Stress Section Early Career Award

This award recognizes excellence in the science and practice of the psychology of traumatic stress by a psychologist who completed her or his highest degree within the last ten years.

CPA Traumatic Stress Section Lifetime Achievement Award

This award recognizes a career of excellence within the science and practice of the psychology of traumatic stress.

CPA Traumatic Stress Section Student Research Award

This award recognizes the best presentation (poster/oral) given by a student at the annual meeting of the CPA as sponsored by the Traumatic Stress Section.

PTSD Fact Sheet

As you may already know, CPA's *Psychology Works Program* has developed a number of "*Fact Sheets"* that describe topics of relevance to the science and practice of psychology in lay language for readership by the general public. Current fact sheets can be obtained from the CPA website at the following address: http://cpa.ca/psychologyfactsheets/.

It was recently noted by Dr. Lisa Votta-Bleeker, CPA Deputy Chief Executive Officer and Director, Science Directorate, that a fact sheet describing what is known about the psychological science and treatment of PTSD is currently not available from CPA. Dr. Votta-Bleeker therefore called upon the Traumatic Stress Section to fill this important gap.

Responding to that challenge, a committee was struck, currently composed of Drs. Paul Frewen, Anne Dietrich, and Cindy Weisbart. We hereby also request the input of another member(s) of our section; please contact Dr. Frewen at pfrewen@uwo.ca if you are interested in contributing to this worthy endeavour.

We presently envision developing a fact sheet that broadly summarizes the following topics of relevance to understanding PTSD: 1) symptomatology and diagnosis, 2) variants on clinical picture, 3) prevalence, 4) etiology, and 5) treatment. We will also attempt to consolidate additional links to further information about PTSD in the fact sheet.

Our project goals are to write a first draft of the fact sheet for presentation and feedback from our membership at our annual business meeting in Quebec City in June. The sheet will then be revised to incorporate feedback received and circulated for broader peer-review within the CPA membership at large.

If you have any particular recommendations for inclusion in or structuring of the fact sheet, or would like to be a part of the writing and/or review process, please contact Dr. Frewen at pfrewen@uwo.ca.

Student Column

The Trauma and Mental Health Report: Changing Minds About Mental Illness

Sara Rependa, PhD (Cand.)

The topic of mental illness, particularly in relation to trauma is an issue that is receiving a great deal of public attention. Recent news stories such as the Sandy Hook Shooting are bringing all too much attention to the topic of mental illness. Provincially, federally, and corporately funded projects such as the Bell "Let's Talk" campaign are working hard to dispel mental illness myths and create dialogue within the community. And for good reason; professionals within psychological and health community at large agree that the pervasive stigma and misinformation surrounding mental health and trauma can no longer be ignored.

The *Trauma and Mental Health Report* is an online magazine style publication run out of York University that aims to do just this. Originally the publication was launched in February 2011 as *The Trauma and Attachment Report* by Clinical Psychologist and York University Professor Dr. Robert Muller. The publication's primary goal was disseminating research on prevention, treatment, and the implications of interpersonal trauma and attachment disorders to the greater community. In January 2013 the report relaunched with a new look and changed its name to *The Trauma and Mental Health Report* in order to expand its coverage to all issues surrounding mental health.

The publication, written by a talented team of undergraduate students supervised by Dr. Muller, strives to publish articles that disseminate information about trauma and mental health in a way that is interesting and easily accessible to the general public. The writers work to tackle a broad range of topics within mental health in a creative and journalistic style. They write not only news type articles, but also do reviews of new psychological research, interviews with clinicians, book reviews, student made films, and critiques of poetry, music and art.

A recent article *Fixing Gay: Corrective Rape in South Africa* exposes and examines the horrific practice of raping gay and lesbian individuals to "cure" them of their homosexuality. Another recent article *They're Just Kids: Inside a Child Psychiatric Unit* interviews a pediatric nurse as she describes what it is like to work in a childrens' psychiatric unit in a hospital.

Since *The Trauma and Mental Health Report* relaunched its new look in January 2013, its coverage has gone global with readers in the USA, New Zealand, Africa, Britain France and Germany. With its own Facebook page, YouTube channel, and almost 2000 followers on Twitter, the publication is dedicated to utilizing a variety of methods to ensure that it reaches as many people as possible with its important message.

The Trauma and Mental Health Report's message is an important one. With a never ending list of misconceptions and stigma surrounding mental health, the public needs a source of information that is easy to access, easy to understand, interesting, and most importantly, accurate. With a team of more then 15 writers, and a supervising professor and clinician with more then twenty years of experience in the field of trauma research, the publication strives to accomplish this goal.

The Trauma and Mental Health Report is dedicated week to week to providing accurate research, educating the public, and changing one mind at a time about the myths of mental illness.

Please Visit the *Trauma and Mental Health Report* at:

trauma.blog.yorku.ca

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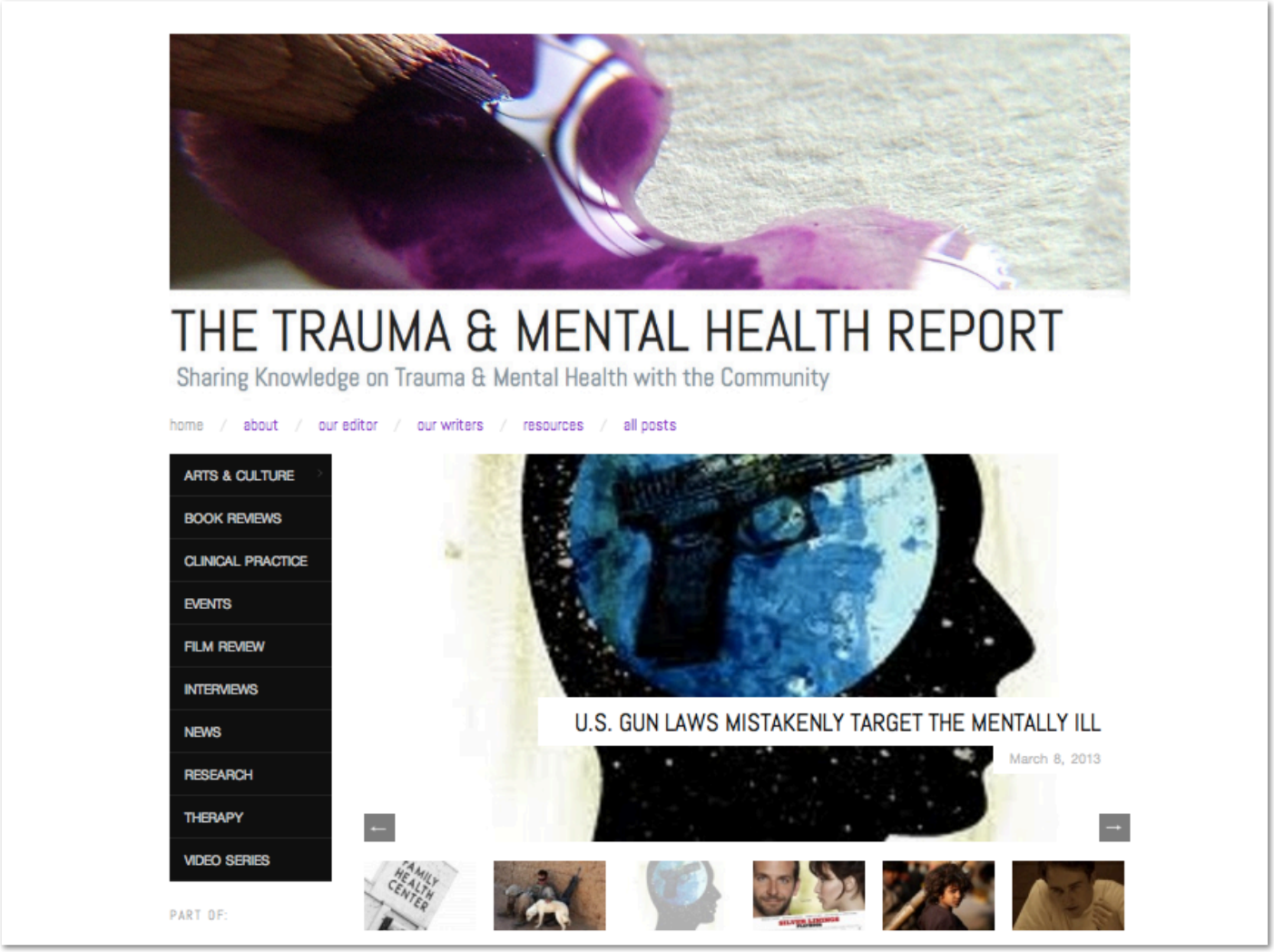

Cognitive-Behavioural Conjoint Therapy for PTSD: Harnessing the Healing Power of Relationships

Candice M. Monson, PhD, C.Psych.

The symptoms of posttraumatic stress disorder (PTSD) result in a substantial burden to individuals, but are also associated with significant interpersonal relationship problems. Epidemiological studies indicate that PTSD is one of the mental health conditions most robustly associated with intimate relationship dissolution and conflict (Whisman, Sheldon, & Goering, 2000), likely because of the inherently interpersonal context of traumatization and the nature of PTSD symptoms. Interpersonal traumas perpetrated at the hands of others are obviously connected to intimate functioning, but even natural or technological disasters and their aftermath are simultaneously experienced in relation to others. Consequently, it is not surprising that the interpersonal factor of social support is the variable most consistently and strongly associated with the onset of PTSD in meta-analyses (Brewin, Andrews & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003).

Consistent with research on the role of interpersonal factors in the onset of PTSD and the connection between intimate relationship problems and PTSD once it occurs, there is a growing body of research indicating that interpersonal functioning affects individual evidence-based PTSD treatment outcomes. For instance, in a large trial comparing cognitive and exposure therapies for PTSD, Tarrier and colleagues (1999) found that high levels of expressed emotion (i.e., hostility and over-involvement) in the families of individuals receiving these therapies were associated with poorer PTSD treatment outcomes compared with those individuals who had families with low levels of expressed emotion. Similarly, in a trial of exposure therapy for veterans with PTSD, Price and colleagues (2011) found that higher perceived levels of emotional/informational support were significantly associated with greater reductions in PTSD symptoms across treatment. It is important to note that there were no changes in social support across treatment, which is consistent with other studies showing no benefit of individual therapy for PTSD on intimate relationship functioning (Galovski, Sobel, Phipps, & Resick, 2005; Monson et al., 2012).

Because of the established role of close others in the onset, maintenance, and treatment of PTSD, and the need to innovate PTSD treatments that can efficiently address a wider range of outcomes and the individuals who may drop-out or not respond to our currently available psychotherapies for PTSD, my colleague, Steffany Fredman, and I developed Cognitive-Behavioural Conjoint Therapy for PTSD (CBCT for PTSD; Monson & Fredman, 2012). CBCT for PTSD is designed to simultaneously address individual PTSD symptoms and enhance relationship satisfaction. Dyads do not have to have clinical levels of relationship distress to be candidates for the therapy; relationship enhancements and/or decreases in partner accommodation of PTSD symptoms may be the goals. In this way, it is best to think of CBCT for PTSD as a first-line PTSD treatment that happens to be delivered in a conjoint therapy frame.

CBCT for PTSD is manualized and consists of fifteen 75-minute sessions comprised of three phases: (1) treatment and education about PTSD and its association with intimate relationships and increasing safety, (2) communication-skills training and dyad-oriented *in vivo* exposures to overcome behavioural and experiential avoidance, and (3) cognitive interventions aimed at changing problematic trauma appraisals and beliefs most relevant to the maintenance of PTSD and relationship problems (i.e., trust, power/control, and emotional and physical closeness). We have accumulated the most evidence for the therapy's efficacy with intimate dyads in which one partner is diagnosed with PTSD (described below). However, we are currently testing it in romantic dyads in which both partners are diagnosed with PTSD and with non-romantic dyads (e.g., mother-son; close friends).

Three uncontrolled studies with Vietnam veterans (Monson, Schnurr, Stevens, & Guthrie, 2004), Iraq and Afghanistan veterans (Schumm, Fredman, Monson, Chard, & Greenwald, in press), and community members (Monson et al., 2011) and their romantic partners indicate improvements in PTSD symptoms and their comorbidities, and some evidence of relationship improvements in couples who may or may not be clinically distressed at the outset of therapy. Improvements in partners' mental health symptoms have also been found (Monson, Stevens, & Schnurr, 2005).

A randomized controlled trial was recently completed with a sample of individuals with a range of traumatic events and different types of intimate couples (i.e., married, cohabitating, noncohabitating, same sex; Monson et al., 2012). This trial found significant improvements in PTSD and comorbid symptoms for CBCT for PTSD compared with waiting list, with treatment effect sizes similar to those found in individual evidence-based treatment for PTSD. In addition, there were significant enhancements in partners' relationship satisfaction that were on par with evidence-based relationship interventions.

It is time to move beyond individual-centric conceptions of posttraumatic stress problems to more fully appreciate the power of interpersonal relations in trauma recovery. CBCT for PTSD offers one empirically-supported and efficient option for clinicians who might either have minimal experience or confidence in treating traumatized others or in providing a conjoint therapy to those who have been traumatized and their loved ones.

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CPA's 74th annual convention

Québec City, QC,

June 13-15, 2013.

See you there!

Introducing Skills Training in Affective and Interpersonal Regulation (STAIR)

Janet A. Schmidt, PhD & Marylene Cloitre, PsyD
National Centre for PTSD, Veteran's Health Administration

Overview:

Among researchers and clinicians both, there is increasing recognition that the experience of multiple versus single traumatization is the rule rather than the exception. Prolonged trauma, particularly when it occurs in early childhood is typically associated with a complex form of PTSD that includes disturbances in emotion regulation, self-organization and relational capacities. Several treatment protocols have been developed to address the full range of difficulties seen in these patients. Below we describe one fairly short-term (3 to 6 month) treatment which has been successful in reducing PTSD as well as emotion regulation and interpersonal difficulties. The treatment also has been successful in reducing dropout compared to therapies which focus predominantly and rapidly on the reappraisal of the trauma.

Skills Training in Affective & Interpersonal Regulation (STAIR) ***followed by Narrative Therapy*** **or what is now called STAIR Narrative Therapy** is an evidence-based treatment for complex form of PTSD (Cloitre et al., 2006). The treatment is comprised of two sequenced modules, each of which is comprised of 8 to 12 sessions. The first module addresses and builds skills in emotion regulation and interpersonal functioning. Desired outcomes include improvement of day-to-day functioning, promotion of self competency as well as client preparation for the processing of trauma memories that occurs in the Narrative module. The aim of the Narrative work is to reduce PTSD symptoms by exploring the client's trauma memories in the form of a Narrative or story. The sections that follow provide the details of STAIR treatment as well as an illustrative case study of a patient with complex PTSD.

STAIR Session by Session Description: The treatment goals of the STAIR phase include (a) enhancing emotional awareness through directed attention and description of feelings as they emerge in daily activities; (b) enhancing emotion regulation capacities by strengthening self-soothing skills, distress tolerance, and the value of positive emotions (c) identifying and changing maladaptive interpersonal patterns, and (d) increasing interpersonal flexibility by developing different expectations for different situations. In concert with the skills training, the therapist provides support, enthusiasm, and positive feedback to the client with the implicit goal of supporting the development of self-efficacy and self-acceptance that facilitates living in the world with compassion and empathy. The session topics follow the order described below. Each session has essentially the same structure: education about the topic, demonstration of a skill, and practice of a skill.

Identifying and Expressing Feeling States (Sessions 1-2). The first sessions of STAIR focus on learning to identify, elicit, and monitor emotional experience. Clients are taught to identify their feelings and corresponding triggers, thoughts, and current mood-regulation strategies. This information is elicited through in-session dialogue and tracked on self-monitoring forms. During this process, the therapist provides positive feedback on the client's work and validation of expressed feelings. An experiential aspect of the intervention arising from the therapist's response is that disclosure of negative feelings can be met with recognition and acceptance by another person. The goals of this exercise, repeated across many sessions, are for the client to develop ease in identifying and describing their feelings and to expect an accepting response, at least in the therapy.

Emotional Regulation Skills (Sessions 3-4). Clients next learn to cultivate effective coping strategies to successfully manage extreme emotions. Clients are guided in identifying both strengths and weaknesses in current coping. Emotion regulation strategies within three channels of experience are systematically identified: bodily experience, cognitions, and behaviors, with an emphasis on engaging in activities leading to increased socialization. Coping strategies that best suit the client's temperament and needs are selected for development and strengthening. Psychoeducation about the value of positive experiences is introduced and pleasurable activities are scheduled.

In these sessions, clients are encouraged to confront distressing situations and difficult emotions rather than avoid them. They are taught skills to enhance their tolerance of distress when considering goals that are of importance to them. Improvement in emotion regulation skills and practice in approach-related behaviors strengthen a sense of efficacy for difficult emotions, thoughts, and situations, and broaden existing behavioral coping repertoires to improve future stress responding.

Expanding the Interpersonal Social Repertoire (Sessions 5-8). The remaining STAIR sessions focus on the identification and revision of maladaptive interpersonal patterns. The patterns are characterized in the form of "interpersonal schemas," which are identified through review and analysis of recent interpersonal experiences. Interpersonal schemas are core beliefs about oneself and others that identify expectations about how others will respond. For those who have been exposed to interpersonal violence or maltreatment, the schemas reflect negative expectations of others based in reality. For example, past experiences may lead someone to develop schemas such as "If I make my needs known, others will not care" (example from a person who experienced neglect) or "If I show my feelings, I make myself and others vulnerable" (example from a combat veteran).

The interpersonal sessions involve the identification of the maladaptive schema and the exploration of an alternative schema. The alternative schema is generated from the articulation of the client's desired interpersonal goals ("I want to people to know more about me" or "I want to be close to my wife") and its specification ("If I disclose my problems, people will be interested and try to help"). Implementation of the new schema is supported by emotion regulation exercises

relevant to the interpersonal goal and repeated role-plays that generate social-emotional behaviors that are consistent with the client's goals.

Therapist/client role-plays are used as a means to bring schemas to life, thereby allowing detailed reviews of interpersonal situations along with specific feedback and recommendations. Role-play of commonly encountered relationship dynamics (e.g., assertiveness, control, flexibility) creates opportunities for the practice of newly learned skills and experience of emotions in a modulated way. Lastly, the relationship between the therapist and client is a therapeutic dimension to the role-play exercises. The therapist expresses support and positive regard of clients even as they struggle in the task to gain mastery of new social-emotional skills.

Narrative Module: ***The Narrative module*** focuses on working through the traumatic memories using an exposure derived Narrative approach. The telling of the trauma and its associated feelings is given as a story with a beginning, middle, and end. The Narrative is told in an emotionally engaged, but regulated way, such that the client is not overwhelmed. While narrating the story, the client (a) learns to regulate the flow of emotion, (b) experiences directed, contained, and goal-oriented emotional expression through the Narrative structure, and (c) strengthens meta-cognitive functioning and self-awareness capacities by being both a part of the story and its narrator. In addition, the therapist and client together explore the meaning of the traumatic experience from the past, as well as the revisions of its meaning in the present, in light of new information gleaned from therapy work.

Research Support for STAIR Narrative Therapy: Cloitre and colleagues (2002) evaluated the efficacy of STAIR Narrative Therapy as compared to a Waitlist condition in a sample of 58 women with childhood abuse-related PTSD. STAIR Narrative Therapy was delivered over the course of the two standard phases. Phase 1 covered eight weekly sessions of affect regulation and interpersonal skills training, while Phase 2 followed with eight weeks of Narrative story telling. In comparison to wait list controls, STAIR Narrative Therapy intervention participants demonstrated significant improvements in affect regulation, interpersonal skills, and PTSD symptoms. Furthermore, gains were maintained at three- and nine-month follow-up periods. At nine-months post-treatment, significant improvements were observed in measures of interpersonal problems, social support, and family, work, and social functioning.

Phase 1 of treatment produced particularly strong improvements in negative mood regulation and anger expression. Therapeutic alliance and improvement in negative mood regulation predicted participants' responses to Phase 2 of treatment. Thus, the role of the therapist and skills training component may enhance the modulation of negative emotions during exposure of the second phase. Overall, treatment outcomes demonstrated significant improvements in interpersonal skills, role functioning, and social support.

A second bench-mark design investigation evaluated a flexible application of STAIR Narrative Therapy in the treatment of survivors of the 9/11 World Trade Center terrorist attack (Levitt, Malta, Martin, Davis, & Cloitre, 2007). Clinicians were allowed to skip or repeat protocol sessions based on their relevance to the patients' symptom presentation and deficits and end treatment prior to completing the entire protocol if satisfactory improvement had occurred. Therapists could also incorporate non-protocol sessions in order to address a current life stressor or crisis that warranted clinical attention. Length of treatment varied between 12 and 25 sessions. Therapists' experience ranged from no prior training to extensive training in cognitive behavioral therapy intervention.

Results showed significant improvements in measures of psychological distress and social and emotional functioning in participants who received the flexibly administered treatment. STAIR Narrative Therapy produced large effect sizes in measures of PTSD and depression symptoms and medium to medium-small effect sizes in measures of interpersonal problems, alcohol and drug use, social support, and functional impairment. Most noteworthy, treatment reduced the reported use of coping strategies reliant on alcohol and drug use and increased the use of social support. Emotion and interpersonal skills training can foster adaptive coping for the management of stress and negative emotions and serve a protective function for future challenges.

Most recently, Cloitre and colleagues (2010) conducted a randomized controlled trial of STAIR Narrative Therapy in 104 women with PTSD related to childhood trauma. STAIR Narrative Therapy was compared to two control conditions: supportive counseling followed by exposure (Support/ Exposure) and skills training followed by supportive counseling (STAIR/Support). Results indicated that participants who received STAIR Narrative Therapy were more likely to achieve sustained and full remission of PTSD in comparison to the two control conditions. STAIR/Exposure participants also demonstrated greater and sustained improvement in anger expression than did Support/ Exposure participants. Of note is the finding that the benefits of STAIR Narrative Therapy emerged primarily at the 3- and 6-month follow-up assessments. Participants in the STAIR Narrative Therapy intervention group evidenced greater improvements in emotion regulation, perceptions of social support, and interpersonal problems than participants in the two control conditions.

Use of the therapy in a group modality in which only the skills training module is implemented , that is STAIR alone, has also demonstrated efficacy as a group-based intervention for chronically hospitalized complex trauma survivors. Trappler and Newville (2007) examined the efficacy of STAIR in a sample of 24 inpatients with co-morbid PTSD and a range of schizoaffective disorders. Compared to a control group who received supportive psychotherapy, patients who underwent STAIR showed significant improvement on measures of psychotic (STAIR z = -4.20, Control z = -0.01) and PTSD (STAIR z = -3.47, Control z = -0.08) symptoms. In terms of specific symptomatology, patients who received STAIR evidenced greater reductions in positive symptoms, emotional withdrawal, tension, depressed mood, unusual thought content, blunted affect, and excitement, as well as, reduced PTSD intrusion and avoidance symptoms.

To summarize, STAIR Narrative Therapy is an efficacious treatment intervention for targeting multiple aspects of trauma-related distress and social and emotional impairments. The therapy has been shown to effectively alleviate symptoms of PTSD associated with early childhood and mass violence trauma exposure and foster continued improvement in mood regulation and interpersonal functioning after treatment has ended (Cloitre et al., 2002, 2010).

STAIR Case Example:

Nora, a 25 year old African American woman presented for treatment in a local clinic after making a suicide attempt combining prescription drugs and alcohol. Nora has been using substances since she was a child and it is likely that many behavioral patterns have developed around substances as a "go-to" strategy for managing stress and are deeply ingrained. Second, Nora has made several suicide attempts, which have occurred in what appears to be an impulsive fashion, where there is a sudden switch from being nonsuicidal to implementing a "fall back" plan of overdosing. Thus, before implementing STAIR Narrative Therapy, the therapist must stabilize the patient medically and establish a "network of care" that probably would involve a physician to consider medication treatment.

During the initial meeting, Nora reveals that she has been the victim of child sexual abuse that began at age seven and continued to age twelve. The abuser was an uncle who routinely babysat the child. Nora tells the therapist that her mother did not believe her when informed about these events. As a "trauma-focused therapy," the STAIR trained therapist would review the effects of trauma in Nora's history in order to help her develop an understanding of her symptoms and to realize that her experience is not unique. The therapist then provides a rationale for the overall structure of the treatment, STAIR Narrative Therapy. The therapist would explicitly state that the initial 8 to 16 STAIR sessions would focus solely on (1) establishing basic self-care activities that protect Nora's baseline day-to-day functioning (e.g., meditation, exercise, focused breathing), (2) strengthening specific coping strategies matched to specific stressors (e.g., managing triggers for using substances) and (3) developing a "safety plan." The safety plan would help identify feelings, thoughts, or events that are early signals of distress in a chain of internal experiences that lead towards urges to self-harm or suicidality. The purpose of the Narrative work would be explicitly discussed and include the following goals: to reduce conditioned fear responses, to develop of a coherent sense of self through story-telling, to appraise the meaning of traumatic events, to share the experience with someone who would "honor" and respect her trauma history, and to ignite Nora's imagination about a possible future "self" that transforms her past experience into some good.

During the approximate 8 sessions of STAIR, the therapist would work use psychoeducation to explain the nature of trauma and its impact; do skills training in identification of feelings, managing emotions using techniques such as muscle relaxation; create lists of pleasurable activities to do alone or with others; help clients recognize their "schemas" and how they impact present relationships, thoughts and feelings; and finally work on managing conflicts, assertiveness and the expression of positive and negative feelings. For Nora, identification of any feelings, especially negative was very difficult since the adult figures in her life had invalidated or ignored her emotional needs. The therapist used STAIR exercises to help Nora learn words to describe her feelings and then how to link physiological arousal with specific feeling terms. Later, the therapist helped Nora tie the difficulty in her emotional expression to the use of alcohol and drugs to "dampen" or numb her feelings. Toward the end of the STAIR, the therapist and Nora identified a key schema ("I am worthless") as a lens through which she interpreted her life. They worked to change this view using self monitoring and generation of alternative points of view and lessen its impact on her negative self judgments and low expectations of others.

If Nora has progressed in use of STAIR based skills and had demonstrated good emotion regulation capacities for the previous three months as reflected in regular use of coping skills when distressed, narrative work would begin. The STAIR Narrative therapist must also obtain Nora's view about the relationship between engaging in trauma narration and the risk for experiencing emotional deterioration or relapse. Contingency plans should be created. During the narrative phase, the therapist should explore whether the absence of discussion of Nora's trauma history, including continued denial by family members, might have led to and continue to reinforce Nora's symptoms. In addition, while not directly addressing the specifics of Nora's trauma history, the therapist would provide some general observations that trauma, in particular childhood abuse, can undermine the development of healthy coping strategies and lead to coping strategies shaped by the "learning history" of her abuse. The goal of these discussions would be to provide Nora with self-compassion and motivation to change rather than continued self-loathing and self-paralysis that might otherwise be occurring. For Nora, the Narrative phase is highly cathartic since she feels both acknowledged and supported for the first time in her pain by her therapist. Because of the pacing and skills learned, she can modulate her feelings during the story retelling and she paradoxically learns she can both remember and move on.

The therapist would conclude formal work with Nora by reviewing what specific coping skills, enjoyable activities, support network individuals were most effective in helping her negotiate day to day obstacles and disappointments. A safety plan would likely be explicitly created given Nora's history of suicidality, which would include emergency contact with the therapist as well as other professionals and reliable friends.

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Announcement

Psychologist – Primary Healthcare Physician Collaboration
A Ten Minute Commitment - Your Opinion Needed

For the past six years I worked closely with primary healthcare physicians in British Columbia and have observed the possibilities of interprofessional care. Consequently, I am interested in the opinions of psychologists regarding their professional contacts with physicians. Your participation in this research is important as it represents an unstudied phenomenon in the collaboration literature. The results of this doctoral dissertation research will be important in furthering understanding of ways to optimize collaboration to improve patient care and may help to further the profession of psychology in Canada. A link to my study is included with the hope that you may participate yourself and forward it along to any colleagues who might also be interested in participating.

As a professional, I realize you are busy. Any assistance with either completing my survey and/or forwarding it to other colleagues is genuinely appreciated. I will send you a summary of my results if you email me at the address below with the subject line, Summary of Results.

Survey Information

I am looking at the factors in optimal psychologist – primary healthcare physician (P-PHCP) collaboration.

Individuals are invited to participate if they are licensed or registered psychologists in Canada and currently work with clients.

Participation in this study will take approximately **ten minutes** and involves the completion of an online survey, which includes information about demographics and questions about attitudes about P-PHCP collaboration.

The Antioch University Institutional Review Board has approved the study. You may contact me at mdrewlo@antioch.edu, Professor Patricia Linn, PhD, Dissertation Chair at plinn@antioch.edu or 206-268-4825; or the Antioch University Institutional Review Board, c/o Alejandra Suárez PhD, asuarez@antioch.edu or 206-268-4823.

At the end of the survey, participants may choose to enter their contact information for a chance to win one of five $50.00 gift cards for Indigo Books.

To participate please copy and paste the following link into your address bar:

http://fluidsurveys.com/s/psychphpcollab/

Thank you in advance!
Margaret Drewlo, MA
Doctoral Student
Antioch University Seattle

Happy Spring!

Newsletter Committee

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Call for Newsletter Submissions

We are excited to develop our Fall 2013 newsletter and need your help!

All section members are welcome to submit brief aticles, commentary, reviews, call for submissions and any other opportunities relevant to our section.

If you are interested please contact catherine.classen@wchospital.ca by July 15, 2013