Healing Trauma

A Professional Guide

Edited by Kitty K. Wu, Catherine S. Tang and Eugenie Y. Leung

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Contents

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Ms Kam-mei Lau is currently studying for a MPhil degree in the Department of Applied Social Sciences of the Hong Kong Polytechnic University. She graduated from Aston University (UK) with an honours bachelor degree in Human Psychology with Professional Training. She has two years of experience working as a research assistant under supervision of clinical psychologists and neuropsychologists in the hospital as well as university settings. Her research interest is mainly looking into neuropsychological profiles of different groups of patients such as HIV-infected persons, persons with Parkinson's disease and multiple sclerosis. Besides working with clinical groups, she also has experience working with the elderly and secondary school students in the community for different research projects.

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Dr Frendi Li is an Assistant Professor in the University of Hong Kong, teaching mainly in the clinical psychology training programme. She has extensive experience in mental health services in the public sector both in Hong Kong and England before starting her teaching career with the University of Hong Kong. She also keeps a very active private practice. Child abuse was the focus of Dr Li's doctoral research in which she studied the efficacy of child abuse prevention programmes as well as that of treatment programmes for survivors. In her clinical experience in helping adult survivors of child sexual abuse (CSA), Dr Li has felt for their pains and difficulties, and therefore feels strongly that society should take CSA prevention seriously. Her chapter discusses the fallacies of "piecemeal" preventive measures that are inconsistent with theoretical knowledge and research findings, and advocates a centrally co-ordinated public health approach in CSA prevention.

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Dr Li graduated from the University of Hong Kong in 1978 and received neurology training at the Regional Neurological Centre, Newcastle General Hospital in England from 1982 to 1984. He is an accredited specialist in neurology and is also the Consultant in charge of the AIDS Clinical Service at Queen Elizabeth Hospital. He has been the Chief of Service of the Department of Medicine, Queen Elizabeth Hospital since 1996. He is serving as Honorary Advisor for a number of local neurology patient groups and is also the Vice Chairman of the Hong Kong AIDS Foundation.

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Mr Wilson Wong studied sociology during the undergraduate level, then continued his postgraduate research studies on various aspects in international law, public administration, public service management, and social policy analysis. He received his higher degrees in academic institutions both in Hong Kong and the UK. Mr Wong has acted as Deputy Secretary General of the Hong Kong Red Cross and has been involved in humanitarian and relief work for 20 years. He has travelled to over 50 countries and over three quarters of the provinces in China, and actively participated in both local and overseas disaster-related projects. He worked in Rwanda during the genocide period and was appointed by the International Red Cross Headquarters in Geneva to be a core team member responsible for the worldwide coordination for the 2004 tsunami relief operation. Besides, he has been a member of the United Nations Office for the Coordination of Humanitarian Affairs and one of the major leaders in the Sichuan earthquake relief action in 2008.

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Ms Delphine Yau works in the public social services sector in Hong Kong. She provides help mostly to children and families struggling with an array of different problems. Issues of abuse, violence and trauma are her special areas of interest. In recent years, she became very much influenced by post-structuralist thinking, particularly narrative ideas, and actively engages in narrative practice in consultations with children and families.

Part I

Introduction

The greatest discovery of my generation is that human beings can alter their lives by altering their attitudes of mind.
– William James, 1842–1910

1

Gateway to the Future

Kitty K. Wu, Eugenie Y. Leung, and Catherine S. K. Tang

The development of work and research on traumatic stress has come a long way in Hong Kong. Perhaps, the answer for the future lies in the possible paths that can be taken after essential milestones have been passed in the journey. The setting up of the Critical Incident Team (CIT) in the Division of Clinical Psychology of the Hong Kong Psychological Society in 1993 was among the first and vital milestones which helps to establish the role of clinical psychology in trauma work for Hong Kong's community (Leung, Wong, Li, Lau-Yu, and Wu, 1993; Leung et al., 1996; Leung and Wu, 2005; Wu, 2005; Wu, Lu, and Leung, 1995). The development of disaster service occurred in various government departments, including the Social Welfare Department, the Hong Kong Hospital Authority, as well as various non-government organizations (Lau, Ch. 11; and Wong, Ch. 12), involving different disciplines e.g., nurses, doctors, social workers, psychologists and psychiatrists. This development signified the recognition and inclusion of psychological service for disaster and trauma recovery in the overall management plan of government bodies and community organizations. Although it implies greater availability of resources and manpower, continuous development and up-keep of quality of service are required for the advancement of community service for survivors of small-scale but significant traumatic stress, such as child sexual abuse (Li, Ch. 6; Ma and Yau, Ch. 7). Areas for further development include prevention of traumatic events, enhancing preparation, resilience and recovery of the community when confronted by traumatic experiences.

The setting up of the Asian Society for Traumatic Stress Studies (AsianSTSS) in 2005, a multi-disciplinary body which aims to provide a platform for knowledge exchange and seeks to influence the way trauma psychology is addressed in public policy and the media, indicates that mental health issues related to trauma is no longer the monopoly for a small group of professionals. Various professional bodies and related agencies have to play the role of community watchdogs in order to advocate for high-quality and comprehensive mental health service, and research for prevention and recovery purposes. The position paper and press release of a public survey on the psychological impact of road crashes presented by the AsianSTSS in June 2008 (please refer to the annex of this chapter) can be regarded as a blueprint for future advocacy in raising public awareness and influencing public policy (Asian Society for Traumatic Stress Studies, 2008; Wu et al., 2008).

The ease of information exchange made available by technology has facilitated dialogue and links between Hong Kong and the international trauma professionals. Information and databases can now be accessed easily via the internet, such as the revised treatment guidelines presented in Effective Treatments for PTSD, Second Edition, developed under the auspices of the Posttraumatic Stress Disorder (PTSD) Treatment Guidelines Task Force established by the Board of Directors of the International Society for Traumatic Stress Studies (ISTSS, 2009; Foa, Keane, Friedman, and Cohen, 2008). Also available are the clinical guidelines on PTSD from National Institute for Health and Clinical Excellence (NICE, 2005), the Guidelines on Mental Health and Psychosocial Support in Emergency Settings developed by WHO's Inter-Agency Standing Committee (IASC, 2007) and Framework for Mental Health and Psychosocial Support After the Tsunami provided by the World Health Organization (WHO, 2005). The advancement of public knowledge will inevitably lead to the increase in demand and pressure that calls for evidence-based service in line with the international standard for assessment (Wu, Ch. 2) and treatment of traumatic stress (Wong, Ch. 3 and Cheung, Ch. 4). This is an important mission for mental health professionals in trauma work in Hong Kong to accomplish, especially due to the demand for knowledge exchange and experience-sharing with counterparts in Asian societies, including mainland China, Korea, Macau, Singapore and Taiwan, reaching another milestone in the development of trauma work and research in Hong Kong. To justify the export of knowledge and practice to our neighbouring communities (Tang, Ch. 14 and Wu, Ch. 13), it is necessary for Hong Kong professionals to observe international guidelines and attain excellence in providing service and conducting research of an international standard.

The development of trauma psychology in Hong Kong was built from various lessons learnt from different public services and non-government organizations (NGOs) responding to traumatic incidents in Hong Kong and places around us. Starting from the Lan Kwai Fong Incident in Hong Kong in 1992 to the recent Sichuan 5/12 Earthquake in 2008, we witnessed significant advancement of applied psychology both in Hong Kong and in the international field of behavioural science. The accumulation of knowledge regarding the use of single-session debriefing, such as Critical Incident Stress Debriefing (CISD), is a good example for reviewing the advancement of knowledge and practice in trauma psychology. CISD was excitedly embraced (Everly and Mitchell, 2000; Mitchell and

Everly, 1996) as a promising preventive measure for posttraumatic stress disorder (PTSD) in the 1990s, which provided insight to mental health workers about their role after disaster. It has now become a topic attracting sensational and defensive debate and controversy (e.g., Bisson, McFarlane, and Rose, 2000; Rose, Bisson, and Wessely, 2002; van Emmerick, Kamphuis, Hulsbosch, and Emmelkamp, 2002), dividing practitioners into groups of CISD followers and challengers, for an initially well-intended psychological intervention was later found to be possibly harmful for the people it was meant to serve. For various reasons, single-session debriefing in the form of CISD is still utilized by a number of public bodies in Hong Kong (Lau, Ch. 11). We believe the exchange of views and knowledge on the controversy related to CISD, no matter applied to a homogenous group of personnel or the community, as a component of an overall management plan or an independent measure, would help to enhance rational evaluation of its utilization in future (Lau, Ch. 11 and Wong, Ch. 3).

In the international arena, the trend of utilizing the "doing-no-harm and evidence-informed" approach like Psychological First Aid (PFA) (Brymer et al., 2006a) instead of single-session debriefing has been a major leap for the application of psychology in disaster work. This is an inevitable step of development as psychological service is subjected to objective and scientific evaluation and required to be aligned to international standard of practice (e.g., National Institute for Health and Clinical Excellence, 2005; World Health Organization, 2005). The adaptation of PFA for application in community traumatic events (Brymer, Brian, Reyes, and Macy, 2009), e.g., for families (Cullerton-Sen and Gewirtz, 2009) and youth experiencing homelessness (Schneir, 2009), and specific application by community religious professionals (Brymer et al., 2006b) suggest increased possibility of examining the efficacy of the evidence-informed practice (Wong, Ch.12).

Evidence showed us that if a safe environment with basic daily needs and psychosocial support is provided, the majority of disaster survivors will recover psychologically. Thus, the limited resources of mental health professionals could now be geared more effectively towards training community-level workers in PFA and psychological support, while providing focused professional intervention for those who suffer from persisting psychological impairments. This has paved the way for enhancing PFA skills for workers in humanitarian organizations and NGOs and encouraging their participation in the development of disaster psychology. Like physical first aid, enhancing PFA literacy of the community at large might be the emerging trend in the development of trauma psychology. When community-level workers or volunteers are trained and base their work on evidence rather than good intention, it is justifiable for the public to expect mental health professionals to provide timely intervention for those who suffer more severe distress by utilizing evidence-based treatment. Both community-level workers and mental health professionals need to be continuously equipped with updated evidence and knowledge, and utilize the most culturally sensitive and appropriate skills when responding to people and communities in need (Wong, Ch. 12; Wu, et al., Ch. 13 and Wu, 2009).

The third milestone documented in this book is the accumulation of knowledge via research on and practice in assessment (Wu, Ch. 2) and understanding psychological sequel, including psychological distress and growth of traumatic experience (Ho, Wong and Chung, Ch. 5; Au, Chan, Li and Lau, Ch. 9), and rehabilitation services for people affected by various traumatic stresses including interpersonal trauma (Li, Ch. 6; Ma and Yau, Ch. 7; Chan, Ch. 8), health and medical trauma (Au et al., Ch. 9 and Tse, Ch. 10), and mass trauma and disaster (Lau, Ch. 11; Wong, Ch. 12; Wu, et al., Ch. 13). This knowledge base will empower future research to study the subject in greater depth for a variety of traumatic or applied conditions. The utilization of an empirical approach in examining knowledge and service is fundamental for developing research and practice that are culturally relevant for Hong Kong and Chinese societies at large (Wu, et al., Ch. 13).

Together with mainstreaming trauma psychology in university and professional training curriculum in recent years (Tang, Ch. 14), more students from both the undergraduate and post-graduate professional curriculum of different disciplines, will be equipped with knowledge on mental health issues related to trauma. Consolidation of this educational bridge that helps to strengthen the link between research and practice, academic work and community awareness would be meaningful future directions for promotion of mental health related to traumatic stress in our society.

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Annex

The Position Paper of the Asian Society for Traumatic Stress Studies on Psychological Impact of Road Traffic Accidents (Hong Kong Chapter)

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1. The Asian Society for Traumatic Stress Studies (AsianSTSS) acknowledges the adverse psychological and social impact of road traffic accidents and advocates for the early intervention and prevention of these adverse effects as an outcome of road traffic accident.
2. The AsianSTSS is a multi-disciplinary organization that advocates the promotion of knowledge about preventing traumatic events, understanding the scope and consequences of traumatic exposure, and ameliorating their consequences.
3. Road traffic accidents (RTA) are a threat to people's physical, psychological and social well-being and could potentially lead to long-term mental disabilities or diseases. RTA could also threaten the health and socioeconomic well-being of a community, in particular, population of the low and middle income levels.
4. For every person who dies in a road traffic accident, many more are left with permanent disabilities. Studies reveal that RTA could lead to major mental health problems (e.g., depression and post-traumatic stress disorder) and socioeconomic difficulties (e.g., limited daily activities, social life and work problems).
5. According to the World Health Organization (2002), RTA was the 11th leading cause for mortality worldwide and the 9th leading contributor to the global burden of disease. Road safety has also been recognized by WHO as a major health promotion focus and the theme for World Health Day 2004. WHO has warned that, on current trends, road traffic injury will become the 3rd leading contributor of global burden of disease by 2020. To enable more reliable estimates of the global burden of road traffic injuries and to enhance planning of rehabilitation services, especially for the low-income population, improvement in the collection and analysis of data is needed. As recommended by WHO, these include data on acute morbidity and long-term disability, economic and social impacts

of road traffic injuries, especially for the low-income and middle-income populations.

6. To prevent traumatic stress caused by RTA, we need a safe environment for all road users and oppose practices that would compromise road safety.
7. The mortality rate of RTA in Hong Kong is among the lowest in the world's major countries. This has to be acknowledged as an asset of Hong Kong that needs to be protected and valued.
8. Improved professional awareness on the potential distressing psychological and social impact of RTA would be needed to promote the followings in Hong Kong:
   i. observation and documentation of psychological functioning at the acute phase;
   ii. provision of early and comprehensive psychological and social intervention for victims affected by RTA;
   iii. collection and analysis of data on long-term disability, economic and social impacts of road traffic injuries.
9. Public education on road safety has been provided by the HK government in the past with a good result. However, there are still gaps in coverage. To address the existing gaps, public education would also need to focus on the psychological and social impact of RTA in order to achieve the following:
   i. increase public awareness on the psychological and social impact of RTA;
   ii. enhance public knowledge on the help-seeking channels available for psychological and social distress caused by RTA;
   iii. increase empathy for victims of RTA and promote safe use of road;
   iv. advocate for a supportive environment for victims of RTA within the family, at the workplace, and in society at large. Survivors who suffer from travel anxiety or posttraumatic stress after an RTA would require safe transportation and environment for practice of normal travelling in order to re-build confidence. Support from family and employers are essential in this rehabilitation process.
10. We hope, with the concerted efforts among the Hong Kong government, professionals, and the public, this will help to minimize long term disability arising from RTA, and to help those living with disabilities to achieve maximum independence, better quality of life and be reintegrated back to the society. These mean participation in ordinary daily activities, including their work, as far as possible.

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Part II

Assessment and Intervention

Hope is both the earliest and the most indispensable virtue inherent in the state of being alive. If life is to be sustained hope must remain, even where confidence is wounded, trust impaired.

– Erik H. Erikson, 1902–1994

2

Trauma Assessment Tools Validated in Hong Kong

Kitty K. Wu

According to the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR; American Psychiatric Association 2000) the prevalence rate of Acute Stress Disorder for individuals exposed to trauma ranges from 14 to 33%. The lifetime prevalence rate of Posttraumatic Stress Disorder (PTSD) in community-based studies is approximately 8% for the adult population in the United States. PTSD can also occur in childhood. For children, previous studies found that PTSD can be associated with cruise ship sinking (Yule and Udwin 1991), sexual abuse (Alexander 1993; Murphy, Kilpatrick, Amick-Mcmullan, and Veronen 1988) and child survivors of war (Dyregrov, Kuterovac, and Barath 1996; Thabet and Vostanis 1999).

There are a number of measures for screening of acute stress disorder and PTSD (Carlson 1997; Norris and Hamblen 2004; Orsillo 2001). However, the availability of validated Chinese versions of PTSD-related assessment instruments for clinical and research use is limited. The present chapter aims at summarizing the psychometric properties and previous findings of assessment tools for traumatic stress that have been translated into Chinese and validated in Hong Kong. These include, for examining traumatic stress in adults, two self-report measures, namely, the Impact of Event Scale-Revised (IES-R; Weiss and Marmar 1997; Wu and Chan 2003, 2004) and the Posttraumatic Stress Disorder Checklist (PCL; Weathers, Litz, Herman, Huska, and Keane 1993; Wu, Chan, and Yiu 2008), a clinician administered structured interview, namely, the Clinician-Administered PTSD Scale for DSM-IV (CAPS-DX; Blake, Weather, Nagy, Kaloupek, and Charney 1995; Blake et al. 1998). For examining dissociative experiences, the Chinese version of Dissociative Experiences Scale (DES; Bernstein and Putnam 1986; Carlson and Putnam 1993) is introduced. Although this Chinese version of DES (Cheung et al. 2007) has not yet been validated, it has been translated into Chinese with stringent back-translated procedure and the inclusion of this scale aims to encourage research for examining its psychometric properties and related condition in future studies. For examining traumatic stress in children and adolescents, one self-report measure, namely, Children's Impact of Event Scale-Revised (CHIES-R) is included (Wu, Chan, Hung, and Cho 2008).

For Adults

Impact of Event Scale-Revised (IES-R)

The Impact of Event Scale (IES; Horowitz 1976) was widely used for exploring the psychological impact of a variety of traumas. The theoretical formulation of the IES is based on clinical studies of psychological response to stressful events, and on the theory about stress response syndrome (Horowitz, Wilner, and Alvarez 1979). The IES was developed to study the intrusive experience and avoidant behavior in reaction to traumatic events. As noted by Weiss and Marmar (1997), the IES and research data collected help to provide evidence that contributes to the adoption of posttraumatic stress disorder (PTSD) in the nomenclature, which was first recognized as a diagnostic entity in DSM-III (American Psychiatric Association 1980). According to a recent review, the psychometric properties of the IES has been demonstrated in numerous studies and utilized in research studying the psychological impact of various traumatic life events. Results indicate that the IES's two-factor structure is stable over different types of events, and it has convergent validity with diagnosed PTSD (Sundin and Horowitz 2002).

Weiss and Marmar (1997) revised the IES by inclusion of items tracking responses in the domain of hyperarousal symptoms. Such revision was consistent with the inclusion of hyperarousal symptoms in the diagnostic criteria of PTSD in DSM-IV and DSM-IV-TR (American Psychiatric Association 1994, 2000). Together with the 15 items in the original IES, the IES-R comprises 22 items. It is a self-report measure that can be administered in approximately 5–10 minutes. Previous findings have demonstrated the sound psychometric properties of the original IES-R in English with internal consistency examined by Cronbach's alphas ranging from .79 to .91, and test-retest reliability alphas ranging from .51 to .94 (Weiss and Marmar 1997).

Compared to other self-report measures that are specifically tied with the specific disorder of PTSD, e.g., Posttraumatic Stress Disorder Checklist (Weathers et al. 1993), the strength of the IES-R lies in the vast amount of literature based on the utilization of the original IES. The use of the IES-R allows for replications of previous studies and comparisons of findings between previous and new research areas. Since IES-R focus on the impact of an event and is relatively independent from any specific disorder, the IES-R can serve as an instrument to examine the associated features of various, but not just one, psychological syndromes.

Compared with structured interview in assessing PTSD features, IES-R is brief and easy to administer. The IES-R has also been used for treatment studies (Maercker 1999). Since the IES-R is one of the few PTSD-related self-report measures that has been translated into different Asian languages and validated in different studies, the utilization of IES-R allows comparison of results between studies of different traumatic events for the Asian population (Asukai et al. 2002). The Chinese version of IES-R (Appendix A) has been found to have satisfactory psychometric properties in studies examining the psychological impact of traumatic event for adults (Wu and Chan 2003, 2004). The Chinese IES-R has been used as a measure to evaluate outcome in treatment studies (Chan et al. 2005; Wu 2002) and to examine the course and psychological factors associated with the development of posttraumatic stress for survivors of road traffic accidents (RTA; Wu and Chan 2004; Wu and Cheung 2006) and Severe Acute Respiratory Syndrome (SARS; Ho, Kwong-Lo, Mak, and Wong 2005; Lee et al. 2007; Lee, Chi, Chung, and Chou 2006; Wu, Chan, and Ma 2005a, 2005b). Since the IES-R focus on the impact of an event, it has also been used for studying the impact of media coverage on community stress level after the South Asia Tsunami (Lau, Lau, Kim, and Tsui 2006). The simplified Chinese version of the IES-R has also been used for screening of persisting psychological distress for survivors of the 5/12 Sichuan Earthquake who required orthopedic rehabilitation, showing that it is applicable for the Chinese population in mainland China (Wu, Ip, Hung, Chan, and Leung 2009).

Scoring

The scoring of the Chinese IES-R follows the procedure suggested by the authors of the original IES-R (Weiss and Marmar 1997; Wu and Chan 2003). The degree of distress for each item is rated on a five-point scale, ranging from the absence of a symptom (scoring zero) to maximum symptomatology (scoring four). There are three subscales (i.e., I, representing intrusion; A, representing avoidance; and H, representing hyperarousal). Items for the specific subscale are labelled as I, A, or H in the right hand margin of the scale. Subscale scores are equal to the mean score of the non-missing items for the specific subscale e.g., if 6 items of the Hyperarousal scores were answered, the subscale score for hyperarousal is equal to the mean of the scores for the 6 items completed.

According to the original study on IES-R, there are no “cut-off” points for the IES-R. The IES-R is intended to give an assessment of symptomatic status over the last 7 days with respect to the 3 domains of PTSD symptoms stemming from exposure to a traumatic stressor. Neither the IES-R, nor the original IES was intended to be used as a proxy for a diagnosis of PTSD. On the other hand, the anchor points for different scores can be used as references for interpreting scores.

For example, if the subscale score on Intrusion was 1.88, that would indicate that for this person in the last week his or her distress from intrusive symptoms was close to, but not quite moderate.

According to a normative study on the Chinese IES-R for a group of patients who attended Accident and Emergency Service (A&E), a mean score of 2.0 on a specific subscale was indicated as the psychometrically appropriate score for screening of a moderate level of distress that might require further clinical attention (Wu and Chan 2003). Previous studies using Chinese IES-R for survivors of RTA and SARS have also used the mean score of 2.0 as the score for indication of a moderate level of distress associated with PTSD features requiring clinical attention. However, common limitations of utilizing a particular score or cut-off points for screening have to be considered. Issues such as the time elapsed since the traumatic event and the severity of the traumatic event would undermine the validity of cut-off scores. Moreover, the base rate of stress reactions will vary significantly depending upon the sample being studied, e.g., survivors of a RTA with no casualty versus women who have been raped; and variation in base rates may weaken the validity of any fixed cut-off.

Reliability and internal consistency of the Chinese version of IES-R

The Chinese IES-R subscales have demonstrated fine internal consistency with Cronbach's alphas ranged from .83 to .92; split-half reliability alphas ranged from .83 to .90; and test-retest reliability alphas ranged from .52 to .76 for a one month interval (Wu and Chan 2003, 2004). As PTSD is characterized by the presence of all three domains of distressful features, the percentage of participants passing the score of 2.0 for all three IES-R subscales was compared with the diagnostic result of the Clinician-Administered PTSD Scale for DSM-IV (CAPS-DX; Blake et al. 1998), a clinician administered structured interview for the diagnosis of PTSD, in a study examining 46 RTA survivors one month after the RTA. With the CAPS-DX result set as the gold standard, the IES-R was found to have 100% sensitivity and specificity for screening of PTSD (Wu and Chan 2004). With the subscale score of 2 as the cut-off in a study of 575 RTA survivors who required A&E services, 5–20% of them reported significant level of distress related to one to three of the PTSD symptom clusters within 6-month after the RTA (Wu and Cheung 2006). In a study examining 195 SARS survivors one month after they were discharged from hospital, 10–15% of them passed the cut-off of 2 indicating moderate level of distress in one of the IES-R subscales, and 6% were found to have all the three IES-R subscale scores greater or equal to the cut-off (Wu et al. 2005b). When 131 of these survivors were examined three months after their discharge from hospital, there were 8–14% who passed the cut-off of one of the IES-R subscales, and 5% were found to have all the three IES-R subscale scores passing the cut-offs (Wu et al. 2005a). Though the Chinese IES-R was found to have satisfactory validity in screening of PTSD features in these local studies, the percentage of subjects who passed the cut-off could not be considered as the prevalence for actual PTSD diagnosis because IES-R is not a diagnostic tool and Criterion A for PTSD in DSM-IV-TR (American Psychiatric Association 2000) was not specifically assessed in these studies.

Factor structure and subscale independence of the Chinese version of IES-R

According to a Hong Kong study for non-traumatized patients who needed to attend A&E services and the original study for the English version, an underlying structure with one factor was identified (Weiss and Marmar 1997; Wu and Chan 2003). This result is inconsistent with Horowitz's stress response theory (Horowitz 1976) and factor structure of the original IES. The one-factor model identified for the IES-R is also not consistent with the dimensionality of PTSD found in studies utilizing measures other than IES-R which suggest that though the three symptom clusters of PTSD according to the DSM-IV might not provide the best conceptualization of symptom dimensionality, a four-factor model provided the best fit to the data (Asmundson et al. 2000; King, Leskin, King, and Weathers 1998; Wu, Chan, and Yiu 2008).

The reason for the failure to identify at least the original two factors (i.e., intrusion and avoidance) in earlier studies was probably related to the level of impact of the focused event for respondents when they filled in the IES-R. In the study by Weiss and Marmar (1997), the data was collected approximately 6 weeks after an earthquake. Whether the earthquake has caused personal impact on these respondents e.g., physical injury, was not documented. In the study by Wu and Chan (2003), a sample of A&E patients, not necessarily had experienced any trauma or traumatic stress, was studied. Thus, most of the respondents in these studies rated themselves as not affected or only a little bit affected by the PTSD features captured by the IES-R.

A two-factor or three-factor structure was found when large samples of subjects with traumatic experience that would likely have a personal impact were studied. In a sample of 658 survivors of the sarin attack in the Tokyo Metro system instigated by the Aum Shinrikyo cult members in 1995, a two-factor model consistent with the stress response theory was identified for the Japanese version of IES-R (Asukai et al. 2002). In a Hong Kong study, a two-factor structure explaining 58% of the variance was found for the Chinese version of IES-R when a sample of 575 survivors who required A&E service after RTA was studied (Wu and Chan 2004). The first factor mainly included items belonging to the Intrusion and Hyperarousal subscales and all items loaded with the second factor belonged to the Avoidance subscale. The correlation between these two factors was moderate for this study (r = .54), which was consistent with the mean correlation (r = .63) between the intrusion and avoidance subscales of the original IES found in previous studies (Sundin and Horowitz 2002). The moderate correlation suggested that the two factors were relatively independent of one another, each of them representing a different type of reactions after a traumatic event. These findings suggest that the two-factor model for the original IES assumed in Horowitz's stress response theory (Horowitz et al. 1979) applies to the Chinese version of IES-R. The first factor found is represented by symptoms for intrusion and hyperarousal, while the second factor is represented by symptoms for avoidance. Thus, the two-factor structure is consistent with the presence of either "overwhelmed" or "frozen" states after traumatic experience as predicted by Horowitz's stress response theory. The two-factor structure found in the Hong Kong study is consistent with the scale structure found in the Japanese study (Asukai et al. 2002). In a recent study on the English version of the IES-R with a sample of survivors who had experienced a serious RTA, a three-factor structure of IES-R — Intrusion, Avoidance, and Hyperarousal — with adequate internal consistency for each subscale, was found (Beck et al. 2008). These findings suggest that IES-R is not simply a measure of general distress. The use of a more homogeneous sample that would likely experience an on-going personal impact of a traumatic event probably ensure greater clarity in reviewing the underlying factor structure of IES-R.

The inclusion of the Hyperarousal items in the IES-R brings the IES up to date with changes in the PTSD criteria and contributes to our understanding of the psychological impact of traumatic events both for empirical study and clinical work. However, more research is needed to establish the dimensional nature of the IES-R subscales with the added hyperarousal items, and to examine whether identified dimensions differ as a function of the trauma experience. As remarked by Beck and colleagues (2008), since IES-R does not correspond exactly to DSM-based definitions of PTSD, it is possible that the IES-R can contribute to the on-going discussion on the underlying factor structure of PTSD. Recent findings on the dimensionality of PTSD symptoms suggest a hierarchical four-factor model (i.e., comprising four first-order factors corresponding to re-experiencing, avoidance, numbing, and hyperarousal all subsumed by a higher-order general factor) (Asmundson et al. 2000; King et al. 1998). In this context, the IES-R Avoidance subscale may provide a more focused examination of effortful avoidance, relative to measures that combine avoidance and numbing together.

Correlates

The rating on the severity of physical injury for RTA survivors was significantly correlated with the Chinese IES-R Intrusion, Hyperarousal, and Avoidance scores

(Wu and Chan 2004). When 195 SARS survivors were examined one month after they were discharged from hospital, women and participants with low education level had a higher Avoidance score, however, these relationships were not significant when a shared sample of 131 SARS survivors were examined three months after they were discharged from hospital (Wu et al. 2005a, 2005b). The relationships between age and various IES-R subscale scores were not significant in studies for RTA and SARS survivors (Wu and Chan 2004; Wu et al. 2005a, 2005b; Wu and Cheung 2006).

The relationships between Chinese IES-R and other measures of mental health including anxiety and depression were moderate to strong. The correlation coefficients between the Chinese IES-R subscale scores and Chinese versions of General Health Questionnaire-20 (GHQ-20: Chan 1995) ranged from .51 to .80, and with the Hospital Anxiety and Depression Scale (HADS: Leung, Ho, Kan, Hung, and Chen 1993) ranged from .51 to .81 (Wu and Chan 2003, 2004; Wu et al. 2005b; Wu and Cheung 2006).

Posttraumatic Stress Disorder Checklist (PCL)

The PCL (Weathers et al. 1993) is a 17-item self-report rating scale that parallels DSM-IV's diagnostic criteria B, C, and D for PTSD. It is a self-report measure that can be administered in approximately 5–10 minutes. The PCL was found to have high test-retest reliability ($\underline{r}$ = .96) and validity as indicated by a kappa of .64 for diagnosis of PTSD from the Structured Clinical interview for DSM-III-R (SCID; Spitzer, Williams, Gibbon, and First 1990).

PCL has been examined in cross-validation studies on victims of different types of trauma, e.g., RTA and sexual assault, using diagnoses and scores from the CAPS, and was found to have diagnostic efficiency ranged from .83 to .90 (Blanchard, Jones-Alexander, Buckley, and Forneris 1996). The PCL has also been used in previous research for studying symptom clustering of PTSD which suggested that the three-symptom cluster of PTSD according to the DSM-IV might not provide the best conceptualization of symptom dimensionality, a four-factor model provided the best fit to the data (Asmundson et al. 2000; King et al. 1998).

The diagnostic sensitivity and specificity of the PCL in different languages have previously been demonstrated. They include the English version (Blanchard et al. 1996; Ruggiero, Del Ben, Scotti, and Rabalais 2003; Weathers et al. 1993), French version (Ventureyra, Yao, Cottraux, Note, and Mey-Guillard 2002), and Spanish version (Marshall 2004). As the administration of the PCL requires roughly 5–10 minutes, it compares favorably to the administration of diagnostic interviews, e.g., CAPS, which constitutes a potential utility of the PCL as a screening measure for the PTSD.

On account of the need for PTSD-related assessment instruments in Chinese, the non-military version of PCL which can be referenced to a specific traumatic event has been translated into Chinese (Appendix B). The psychometric properties of the Chinese version of the PCL has been found to be good in a study of 481 RTA survivors suggesting the use of the Chinese PCL as a valid and reliable PTSD assessment instrument (Wu, Chan, and Yiu 2008).

Scoring

The degree of distress for each item is rated on a five-point scale, ranging from the absence of a symptom (scoring 1) to maximum symptomatology (scoring 5). Items corresponding to different diagnostic criteria of PTSD in DSM-IV (American Psychiatric Association 1994), are labelled as R, A, or H (i.e., R, representing Re-experiencing; A, representing avoidance; and H, representing hyperarousal) in the right hand margin of the scale for easy reference.

In the original study of PCL with Vietnam combat veterans, a total score of PCL was computed by adding the ratings for 17 items, so that possible total score ranges from 17 to 85. A cut-off of 50 on the PCL was found as a good predictor of a PTSD diagnosis in this study (Weathers et al. 1993). However, the use of a total score as the cut-off does not necessarily indicate the endorsement of symptoms in a pattern that fits the DSM-IV criteria. It is also not clear what minimum score, e.g., 2, 3, 4, or 5, should be used to define an item sufficiently endorsed for meeting PTSD criteria. According to a more recent study on the PCL, the best values for diagnostic efficiency that would match with the cut-off scores recommended by previous studies (Blanchard et al. 1996; Weathers et al. 1993) come with the mixed scoring criteria (accepting a minimum score of 3 or 4 based on the particular item) with either a cut-off of total score of 44 or 50 (Ruggiero et al. 2003). In a Hong Kong study examining the diagnostic utility of the Chinese PCL for PTSD, results of these four different mixed scoring criteria were compared with the result of CAPS-DX for the diagnosis of PTSD for a sample of 45 RTA survivors one to two months after an RTA. Results indicated that the four different mixed scoring criteria had the same rate of sensitivity (i.e., no false negative) which was 100%. When a minimum score of 3 was used to define an item sufficiently endorsed for meeting PTSD criteria, the rate of specificity (i.e., no false positive) was 50%. When the minimum individual item score of 4 with either a total score of 44 or 50 was adopted, specificity was 100% (Wu, Chan, and Yiu 2008). Though these findings indicate 100% sensitivity and specificity for PCL with the mixed scoring criteria when a minimum score of 4 was used to define if an item sufficiently endorsed for meeting PTSD criteria, the same cautions have to be taken in utilizing a fixed cut-off for self-report measures as discussed for IES-R. These include issues related to the time elapsed since the traumatic event and the severity of the traumatic event as both would undermine the validity of cut-off scores. Moreover, the base rate of stress reactions will vary depending upon the sample being studied. Also, the sensitivity and specificity of the Chinese PCL for the screening of PTSD has not been adequately tested in the study because of the small sample size of participants with PTSD.

Reliability and internal consistency of the Chinese version of PCL

In a study of 481 RTA survivors in Hong Kong, the mean scores of specific subscale and the total score of PCL were found to have satisfactory internal consistency with Cronbach's alphas ranged from .77 to .82; split-half reliability alphas ranged from .82 to .93; and test-retest reliability alphas ranged from .76 to .84 for a one-month interval (Wu, Chan, and Yiu 2008).

Factor structure and subscale independence of the Chinese version of PCL

In the Hong Kong study with a sample of RTA survivors on the Chinese PCL, the hierarchical four-factor model was examined by confirmatory factor analysis which demonstrated a satisfactory goodness-of-fit (χ^2 (115) = 630.40; CFI = .93; RMSEA = .097; NNFI = .91). Such finding was consistent with previous findings on the original English version of PCL which indicated that the dimensionality of PTSD symptoms was best explained by a hierarchical four-factor model (i.e., comprising four first-order factors corresponding to re-experiencing, avoidance, numbing, and hyperarousal all subsumed by a higher-order general factor) (Asmundson et al. 2000; King et al. 1998).

Correlates

For RTA survivors who needed to attend A&E after the accident, the rating on the severity of physical injury was significantly correlated with the Chinese PCL Re-experiencing, Avoidance, Hyperarousal, and total scores. The relationships between PCL scores, age and gender were not significant for these survivors (Wu, Chan, and Yiu 2008).

The relationships between Chinese versions of PCL and GHQ-20 scores were found to be moderate with correlation coefficients ranged from .69 to .77 showing that the PCL contributed information that was not totally captured by the GHQ-20. As IES-R and PCL were both self-report measures on posttraumatic stress features, the correlation coefficients between the corresponding Chinese versions of IES-R and PCL subscale and total scores were high ranging from .71 to .87 (Wu and Chan 2004; Wu, Chan, and Yiu 2008).

Clinician-Administered PTSD Scale for DSM-IV (CAPS-DX)

The Clinician-Administered PTSD Scale (CAPS; Blake et al. 1990) is a widely used structured interview for assessing PTSD. Administration of CAPS-DX requires trained clinicians and approximately 60 minutes. According to a review of ten years of research, CAPS has good reliability across items, raters, and testing occasions (Weathers, Keane, and Davison 2001). It has fine convergent and discriminant validity, and sensitivity to clinical change. The CAPS-DX (Blake et al. 1998) is a revised version of CAPS following the diagnostic criteria of the DSM-IV (American Psychiatric Association 1994). In previous studies of RTA survivors, test-retest reliabilities were reported to be .90 to .98, and the internal consistency was .94. (Blanchard and Hickling 2004). The CAPS-DX includes a Life Events Checklist for examining Criterion A of PTSD and the CAPS-DX instrument for conducting the diagnostic interview to examine Criteria B, C, D, E and F of PTSD. After orienting the client to trauma assessment, the interviewer would hand the interviewee a copy of CAPS Life Events Checklist. This checklist is a 17-item trauma exposure inventory used for identifying types of exposure to a range of different traumatic events. The CAPS Life Events Checklist and the questions used by clinicians in CAPS-DX instrument have been translated into Chinese and Cantonese (i.e., the Chinese language most commonly spoken in Hong Kong), respectively, with back-translated procedure for study of psychological impact of RTA (Appendixes C and D).

Scoring

CAPS-DX consists of 30 sets of questions assessing conditions for Criteria B, C, D, E, F, and associated features of current and lifetime PTSD. For each of the 17 symptoms of PTSD for Criteria B, C, and D, CAPS-DX assesses both the frequency of occurrence and the severity of symptoms at their worst over the past month on a 5-point scale. For frequency of occurrence, each item is rated from "Never" (scoring 0) to "Daily or almost every day" (scoring 4). For symptom severity, each item is rated from "None" (scoring 0) to "Extreme" (scoring 4). Thus, each item can have a score of 0 to 8. Specific scores for Criteria B, C, and D, respectively, can be found by adding up the item scores belonging to the specific criteria. In studies comparing the results of the present Chinese versions of CAPS-DX and self-report measures of PTSD including IES-R and PCL (Wu and Chan 2004; Wu, Chan, and Yiu 2008), an empirically derived rule of scoring for CAPS-DX for making a diagnosis of PTSD was adopted (Weathers, Ruscio, and Keane 1999). According to this method, each PTSD symptom of Criteria B, C, and D is considered present if the frequency of the corresponding CAPS-DX item is rated as 1 or higher and the intensity is rated as 2 or higher. The severity score of an item is equal to the sum of the frequency and intensity scores. To ensure both a significant overall level of PTSD symptom severity and a distribution of symptoms corresponding to DSM-IV diagnostic criteria, a total severity score of 65 or higher for Criteria B, C, and D together is required for making the diagnosis of PTSD. Clinicians can utilize a scoring form for summarizing results of various diagnostic criteria (Appendix D).

Reliability

Inter-rater reliability is an issue for CAPS-DX which is administered by clinicians. The Chinese version of CAPS-DX has been administered for 54 RTA survivors for studying the occurrence of posttraumatic stress one month after the RTA and found that CAPS-DX has good inter-rater reliability. In this study, the tape-recorded interviews of CAPS-DX conducted by the first assessor for five of the RTA survivors were randomly chosen from the sample for independent rating by a second assessor who was blind to the rating given by the first assessor. Results reviewed that the inter-rater reliability for judging the passing of criterion for individual symptom cluster was 93%, for making the diagnosis of PTSD based on DSM-IV criteria was 100% (Chu 2004; Wu and Chan 2004; Wu, Chan, and Yiu 2008)

Correlates

Since CAPS-DX is a diagnostic interview administered by clinicians, it is usually set as the gold standard for making the diagnosis of PTSD and for examining the diagnostic value of self-report measures in research. As reported earlier, with the result of CAPS-DX result as the gold standard, the Chinese version of IES-R and PCL were found to have good sensitivity and specificity for screening of PTSD (Wu and Chan 2004; Wu, Chan, and Yiu 2008).

When CAPS-DX was administered one month after the RTA for 54 RTA survivors who required A&E service after the accident, the rating for severity of physical injury given by medical doctor in the A&E was significantly correlated with the total score of CAPS-DX by adding the scores for Criteria B, C, and D together ($\underline{r} = .34$, $\underline{p} < .01$) and specifically for the score of avoidance symptoms (Criterion C) in CAPS-DX ($\underline{r} = .49$, $\underline{p} < .001$). The relationships between the CAPS-DX total and specific symptom cluster scores; age and gender were not significant for these survivors (Wu and Chan 2004; Wu, Chan, and Yiu 2008).

The correlations for CAPS-DX scores with those of PCL and IES-R one month after the RTA were found to be high with correlation coefficients ranging from .55 to .76 for IES-R and .59 to .76 for PCL. The correlations between CAPS-DX scores and the total score of GHQ-20 was also significant ranging from .45 for re-experiencing symptoms (Criterion B), .73 for avoidance symptoms (Criterion C), and .51 for hyperarousal symptoms (Criterion D) of CAPS-DX (Wu and Chan 2004; Wu, Chan, and Yiu 2008).

Further examination of the Chinese CAPS-DX is needed for examining its psychometric properties, relationship with other structured diagnostic interviews and clinical conditions other than PTSD in future studies.

User qualifications

Like the original version of CAPS, the Chinese version of CAPS-DX requires trained clinicians for administration. Besides qualified training in general skills for conducting clinical interviews and management of intense emotions that may be experienced by clients suffering with PTSD or related conditions, specific training for administration of the CAPS (National Centre for Posttraumatic Stress Disorder 2008) and familiarity with the CAPS manual and previous research findings of the CAPS (Weathers et al. 2001; Weathers et al. 1999) are required.

Dissociative Experiences Scale (DES)

The original Dissociative Experiences Scale (DES; Bernstein and Putnam 1986; Carlson and Putnam 1993) has been studied in over 35 studies and the scale has been utilized in over 400 published study (Orsillo 2001). The strength of the DES lies in the vast amount of literature based on the utilization of the original DES. The use of DES allows for replications of previous studies and comparisons of findings between previous and new research areas. On the other hand, the DES, which is over 20 years old, has been found to have a number of shortcomings which include psychometrical drawbacks, non-specified time period for reporting, and measuring dissociative experiences that could be both normal and pathological (Orsillo 2001).

The DES consists of 28 items that describe dissociative experiences including experiences of amnesia, depersonalization, derealization, imaginative involvement, and absorption. It is a self-report measure that can be administered in approximately 15 minutes. The comparability of the Chinese DES and the original English DES has been validated by stringent back-translation procedures. Taking into consideration the difference in language and culture, a group of experienced bilingual clinical psychologists first translated the DES aiming at retaining the meaning of each item in the Chinese version. An independent bilingual clinical psychologist back-translated the translated DES into English for content comparison. The content of the final Chinese DES was further verified by back-translation procedure until the meaning of each item matched with the original item. However, the major limitation of this Chinese version of DES is that its psychometric properties have not been validated (Cheung et al. 2007). Thus, the clinical use of this Chinese version of DES has to be based on research findings for the original English version or limited to qualitative interpretation (Appendix E).

Scoring

Like the revised version of DES (Carlson 1997; Carlson and Putnam 1993; Carlson et al. 1991), the Chinese version of DES asks the respondent to circle the percentage of time that best reflects how much he or she has each experienced in their daily life in a format of numbers from 0 to 100 (by 10s).

Subscale means can be obtained based on the result of a study using factor analysis (Carlson et al. 1991). Amnestic dissociation is measured by taking the mean of items 3–6, 8, 10, 25, and 26. Absorption and imaginative involvement is measured by taking the mean of items 2, 14–18, 20, 22, and 23. Depersonalization and derealization is the mean of items 7, 11–13, 27, and 28. The total score is calculated by adding all of the items and dividing by 28. A total score of 30 is used as a cutoff point for defining high in dissociation (Orsillo 2001 for a review of the psychometric properties of the DES).

For Children and Adolescents

Children's Impact of Event Scale-Revised (CHIES-R)

The development of the CHIES-R was based on the Children's Impact of Event Scale (Sclare 1997), which was originated from the IES (Horowitz 1976), and the Chinese version of IES-R (Wu and Chan 2003, 2004). The original research version of the CHIES-R (Appendix F) contains 15 items which include 8 items for intrusion and avoidance features used both in Children's IES and Chinese IES-R; an additional intrusion item "I had dreamt about it" used in the IES-R was included for its clinical relevance for the children population; and 6 hyperarousal items of the Chinese IES-R. According to a study of the CHIES-R with a sample of 61 children and adolescents, aged 8 to 17, who required A&E service after RTA, an 11-item version with a three-factor structure corresponding to intrusion, hyperarousal, and avoidance items accounted for 72.0% of variance was identified (Appendix G; Wu, Chan, Hung et al. 2008). Both versions of CHIES-R can be administered in approximately 5–10 minutes. Though clinicians, with or without the help of parents, may need to explain to younger children about the aim of completing the scale, clinician's or parental participation is not required in completing the CHIES-R. The simplified Chinese version of the CHIES-R has been used for the screening of persisting psychological stress for child survivors of the 5/12 Sichuan Earthquake (Wu et al., 2009).

Scoring

The scoring of the CHIES-R follows the procedure for the Chinese IES-R discussed earlier. The degree of distress for each item is rated on a five-point scale, ranging from the absence of a symptom (scoring zero) to maximum symptomatology (scoring four). There are three subscales (i.e., I, representing intrusion; A, representing avoidance; and H, representing hyperarousal). Items for the specific subscale are labelled as I, A, or H in the right hand margin of the scale. Subscale scores are equal to the mean score of the non-missing items for the specific subscale.

Reliability and internal consistency of the Children's IES-R

In the study of RTA child survivors in Hong Kong, the CHIES-R subscale and total scores were found to have acceptable internal consistency with Cronbach's alphas ranged from .71 to .91; split-half reliability alphas of .54 for the Avoidance subscale which contains 3 items, .71 for Hyperarousal subscale, and .79 for Intrusive subscale; and test-retest reliability alphas ranged from .56 to .74 for a two-month interval (Wu, Chan, Hung et al., 2008).

Factor structure and subscale independence of the Children's IES-R

The three-factor structure found for the 11-item CHIES-R (Wu, Chan, Hung et al., 2008) were comparable with recent findings of a 13-item version IES-R used for child survivors of war in Bosnia (Smith, Perrin, Dyregrov, and Yule 2003). Results of principal component analysis (PCA) suggest that the component loadings of most of the 11 items were higher for the component made up by the items assigned for the same subscale than with other components made up by items assigned for other subscales. However, two particular items which include one arousal item (i.e., I had trouble falling asleep), and one intrusion item (i.e., Pictures about it popped into my mind) might not be specific for differentiation of arousal and intrusion symptoms, respectively, for children in the study. The results of the PCA and subscale correlation in this study suggest that the three subscales of the CHIES-R are related but possibly independent of one another, each of them representing a different type of reaction in face of stressful events. Results of confirmatory factor analysis (CFA) for six items of the CHIES-R selected based on subscale specificity demonstrated a good fit of the three-factor structure which included intrusion, hyperarousal, and avoidance (χ^2 (6) = 6.465, p = .37; CFI = .996; RMSEA = .036; NNFI = .991). This findings support the cross-cultural validity of theoretical and clinical presentations of PTSD for children in Hong Kong.

Correlates

The correlation coefficients between subscale and total scores of CHIES-R, Children Depression Inventory (CDI: Kovacs 1992), and Revised Children's Manifest Anxiety Scale (RCMAS: Reynolds and Richmond 1978) found in this study indicated that the relationships between the subscale and total scores of CHIES-R and those of the other two self-report measures were low to moderate (rs = 0.02 to 0.62). This suggests that CHIES-R scores contribute information that is not captured by other self-report measures of psychological distress for children. For RTA child survivors examined one month after the accident, significant relationships between CHIES-R scores, gender, age, and severity of injury were not identified (Wu, Chan, Hung et al., 2008).

Conclusions

The lack of validated measures in Chinese has led to reliance on test tools and norms developed in Western countries which may cause unstandardized scoring and interpretation due to both translational and cultural discrepancies. The self-report measures presented may potentially serve as tools for screening of posttraumatic stress; evaluation of treatment outcome; study of dimensionality and conditions associated with traumatic stress for the Chinese population; and examining the generalizability of the identified dimensions and conditions across cultures.

Clinically, the IES-R, PCL, and CHIES-R may assist assessment of psychological distress experienced by clinical populations and evaluation of treatment outcome. As suggested by the National Institute for Health and Clinical Excellence (NICE; National Institute for Health and Clinical Excellence 2005) for individuals at high risk of developing PTSD following a major disaster, consideration should be given to the routine use of a brief screening instrument for PTSD at one month after the disaster. Moreover, identification of posttraumatic stress, especially in children, can be improved if survivors of traumatic experience are asked directly about their experiences. In this context, the self-report measures discussed may be considered as a standardized self-report measure for screening of individuals who are at risk of developing prolonged distress after experiencing traumatic events.

On the other hand, most of the measures discussed were designed to evaluate traumatic stress which is only one of the possible outcomes of traumatic experience. As suggested by the World Health Organization (WHO) Framework for Mental Health and Psychosocial Support after the Tsunami in South-East Asia, the low level of help-seeking behavior for PTSD symptoms in many non-Western cultures suggests that PTSD is not the focus of many disaster survivors. WHO is concerned that agencies are over-emphasizing PTSD and creating narrowly defined services that do not serve people with other mental problems (World Health Organization 2005). Thus, comprehensive management of the psychosocial needs of disaster victims should not be limited to screening of PTSD. Provision of education and resources to enhance mental health and mutual support in the community; training of frontline staff to enhance knowledge on the diverse mental health problems that could be encountered by disaster victims; provision of accessible and early intervention have all to be considered.

For clinical and research applications, the limitations of self-report measures must also be considered. All of the self-report measures discussed are not diagnostic and, in particular, Criteria A, E, and F of PTSD are not assessed at all. While these self-report measures may be used by professionals, who have proper training in use of psychometric test, for screening or tracking of treatment outcome, or for research purpose, suitable professional support is required in the administration of these measures and provision of follow-up services if needed. It is required that users have to follow proper professional guidelines in using these measures and fulfill the responsibilities of informing test takers their rights and responsibilities (American Educational Research Association, American Psychological Association, and National Council on Measurement in Education 1999; American Psychological Association 2008; Hong Kong Psychological Society Limited 1998).

Among the measures discussed, CAPS-DX is the only diagnostic tool which can be utilized to diagnose PTSD for clinical and research use. In addition to the conditions required for test users of self-report measures, the CAPS-DX has to be administered by qualified clinicians and researchers who also need to observe the user requirements specified. Moreover, CAPS-DX is designed for the diagnosis of PTSD and does not serve to exclude other mental health problems. Thus, CAPS-DX cannot replace comprehensive diagnostic clinical interviews conducted by clinicians for exclusion of other mental health problems.

The standardization and psychometric properties of these measures are developed with a specific sample, e.g., RTA survivors, potential users need to be familiarized with the limitations related to the psychometric properties and generalizability of findings for each measure. Further study on the applicability and generalizability of these measures for different clinical conditions and populations are suggested. Lastly, the present chapter focused on measures validated in our previous studies, thus, measures included may not be an exhaustive account of all measures that have been translated and validated in Hong Kong.

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3

Psychological Management of Trauma in the 21st Century:

The Role of Cognitive Behavioural Approaches in Conceptualization and Treatment

Chee-wing Wong

This chapter looks at current approaches to trauma management in the local context, and argues that clinicians and healthcare practitioners should continuously be informed of new theoretical developments and research evidence that have been accumulating since the new millennium. Now we can no longer ignore the importance of theoretical and research advances that took place in the last decade which had effectively shaped the conceptualization of psychological effects of trauma in general, and good practice guidelines in particular. If Hong Kong were to stay on par with international standards in healthcare service delivery, practitioners should start to reconsider the work they are doing which supposedly is for the benefit of trauma victims. The most current and influential theories on traumatic stress and salient risk factors in posttraumatic stress disorder (PTSD) will be discussed. Stemming from this is a system of evidence-based strategies in monitoring and treating people who have undergone traumatic events. Treatment strategies from a cognitive behavioural therapy (CBT) framework will range from the initial stress reaction to persistent PTSD that may develop in a small proportion of the trauma victims.

Victims of trauma are psychologically vulnerable immediately after the abnormal experience. Zealous and well-intentioned practitioners often do not hesitate to jump onto the helping bandwagon under the pre-supposed idea that their victims are in dire psychological need, and anything that they can offer will invariable do good. Their enthusiasm is further augmented by the supposition that early psychological intervention for trauma victims will help to decrease their chances of developing posttraumatic stress disorder (PTSD).

A spate of civil disasters in Hong Kong during the 1990s prompted the formation of the Critical Incident Team under the Division of Clinical Psychology of the Hong Kong Psychological Society (Wu, Lu, and Leung 1995).

The preferred intervention strategy at the time was to import into our local context a procedure called Critical Incident Stress Debriefing (CISD) promulgated by Jeffrey Mitchell (Mitchell 1983; Wong and Leung 1994). The CISD model borrowed the concept from military psychiatry to return troops with acute combat stress responses back to action as soon as possible. The procedure was originally intended for rescue and disciplinary personnel involved in protracted or horrific rescue missions. In the ensuing years, CISD was extended to business, schools, hospitals and the military (Everly and Mitchell 1999, pp. 84–85).

The face validity of the debriefing procedure plus polite expressions of gratitude further reinforced the clinician's sense of omnipotence. CISD thus insidiously attained a firm foot-hold in local trauma management work. In the event of a "critical incident", be it domestic violence, traffic carnage, homicide, or suicide of a school-age child, we will inevitably find a psychological expert promulgating to the mass media the foreboding psychological aftermath of PTSD symptoms that are to be expected. This would inevitably be followed by a team of expert counsellors and psychologists descending upon schools or communities to do crisis intervention or debriefing. Institutions and government establishments alike would then feel that their timely intervention would earn praises from the general public and from those victims inconveniently exposed to the traumatic event.

The Effectiveness of CISD

Since Mitchell's seminal article on CISD (Mitchell 1983), debriefing experts and providers have mushroomed across the United States with little question raised on its original agenda that a single debriefing session "will generally alleviate the acute stress responses which appear at the scene and immediately afterwards and will eliminate, or at least inhibit, delayed stress reactions" (Mitchell 1983, p. 36). As more critical thinking followed by randomized controlled trials emerged in the mid- to late 1990s, proponents of CISD were compelled to make several modifications to their original thesis (Everly, Boyle, and Lating 1999; Everly, Flannery and Eyler 2002; Everly and Mitchell 1999; Mitchell 2002; Mitchell and Everly 2001). These include a perfunctory retraction of compelling people to undergo debriefing; re-positioning CISD as one of the ingredients in the larger Critical Incident Stress Management (CISM) process; re-defining CISD that it is not intended to be administered in a single session; and insisting that CISD should be done only in a group format under very strict procedural protocols.

In the last decade or so, research along the lines of meta-analysis and randomized controlled trials (RCT) has provided us with an overwhelming majority of evidence showing either no effect or adverse effects of CISD in preventing or ameliorating PTSD (Arendt and Elklit 2001; Bisson 2003; Bisson, Jenkins, Alexander, and Bannister 1997; Carlier, Lamberts, van Uchelen, and Gersons 1998; Carlier, Voerman, and Gersons 2000; Hobbs, Mayou, Harrison, and

Worlock 1996; Hytten and Hasle 1989; Kenardy et al. 1996; Mayou, Ehlers, and Hobbs 2000). Similar reports were published in peer-reviewed journals of high impact such as *The Lancet* (van Emmerik, Kamphuis, Hulsbosch, and Emmelkamp, 2002), or being listed as key evidence-based references in CISD and PTSD (Rose, Bisson, and Wessely 2001). In the Rose, Bisson and Wessely (2001) review, for example, the authors concluded that "There is no current evidence that psychological debriefing is a useful treatment for the prevention of posttraumatic stress disorder after traumatic incidents. Compulsory debriefing of victims of trauma should cease" (pp. 1–2). For a comprehensive and scholarly review of early psychological intervention, readers are directed to the seminal review paper by McNally, Bryant and Ehlers (2003), which is a must-read for all practitioners involved in early psychological intervention for trauma victims.

Research studies done in the past decade have consistently shown that "debriefed participants fared no better — or even worse — than their non-debriefed counterparts on measures of posttraumatic symptoms" (McNally, Bryant, and Ehlers 2003, pp. 61–62). The most damning evidence came from a three-year follow-up study of the original Hobbs, et al. (1996) road traffic accident victims (Mayou, Ehlers, and Hobbs 2000). Those who scored high on PTSD measures and were not debriefed, showed marked improvement by the 3-year follow-up. On the other hand, those who scored high on PTSD measures but who had undergone debriefing remained highly symptomatic on follow-up. The debriefed group showed more PTSD symptoms, psychiatric morbidity, pain, avoidance, and physical as well as financial problems. The results suggested that debriefing appeared to impede natural recovery from acute stress-related symptoms. Further studies along similar lines showed consistent findings along similar directions, e.g. the Oxford trial of immediate debriefing after road traffic accidents (Clark 2007, personal communication).

With such information at hand, practitioners in Hong Kong can no longer ignore the importance of the theoretical and research advances that have taken place in the last decade which have effectively shaped the conceptualization of psychological effects on trauma in general; and good practice guidelines in particular. Clinical Guideline 26 on posttraumatic stress disorder (PTSD) published by the National Institute for Health and Clinical Excellence (NICE 2005, p. 4), for example, annotated in the first bullet point of the first paragraph in the first page that "For individuals who have experienced a traumatic event, the systematic provision to that individual alone of brief, single-session interventions (often referred to as debriefing) that focus on the traumatic incident should **not** be routine practice when delivering services" (emphasis original).

The following section will focus on the prevailing conceptualization and models of traumatic stress, which underpin best practice standards that have been accepted and promulgated world-wide.

Psychological Coping After Trauma

What has been blatantly ignored in the original Mitchell conceptualization (Mitchell 1983) is the natural psychological resilience of trauma victims, and also their own sources of emotional support. Most people recover from acute stress symptoms within a span of 3 months, even if they do not receive any treatment (Kessler et al. 1995).

Proponents of CISD declined to construe the situation this way. They argued that traumatic stress symptoms will not go away unless they are adequately addressed. Reports of wellness after trauma are signs of denial, dissociation, or avoidance at the outset. With the denial will come the delayed onset of PTSD unless the trauma victims' emotions are being processed via early psychological intervention strategies. Perhaps the September 11 terrorist attacks on New York's World Trade Center could serve as a reminder (Kadet 2002; quoted in McNally, Bryant, and Ehlers 2003). Despite the arrival of over 9,000 grief and crisis counsellors in New York City after the collapse of the Twin Towers, few people turned up for debriefing and the demand for psychological services was far less than most experts predicted. As a result, a sizable amount of funding ear-marked for free counselling for New Yorkers remained unspent. The expected influx of delayed-onset PTSD sufferers never materialized. The morbidity rate for PTSD 8 weeks after the attack of a random sample of adults living south of 110th Street in Manhattan was 7.5%. Three months later, in the absence of active psychological intervention, the PTSD morbidity of the same group dropped to 1.7% showing that most people are resilient and are able to recover from early posttraumatic symptoms themselves. DeLisi et al. (2003, pp. 782) concluded that "those with severe symptoms were far fewer that what we expected, given the magnitude and amount of personal exposure to this disastrous event.".

A similar situation was experienced in Hong Kong after the Lan Kwai Fong stampede disaster, which occurred on New Year's Eve 1992 in a popular bar area jam-packed with revellers. A venue for debriefing was being set-up with much enthusiasm by clinical psychologists and trainees, but the number of clinicians present on the occasion far-exceeded the number of attendees. A number of vulnerable persons afflicted with PTSD were treated on an individual basis months after the Lan Kwai Fong stampede disaster. It was also noted that there was no wide-spread surge of PTSD sufferers as a result of the disaster.

With reference to available research evidence and experience gained from local and the 9/11 attacks, we may need to take heed of the suggestions promulgated by the National Institute of Health and Clinical Excellence Guidelines for PTSD (NICE 2005, pp. 4) which succinctly suggested that "Where symptoms are mild and have been present for less than 4 weeks after the trauma, watchful waiting, as a way of managing the difficulties presented by people with post-traumatic stress disorder (PTSD), should be considered. A follow-up contact should be arranged within 1 month."

Acute Stress Disorder

It is widely accepted that stress symptoms immediately after a traumatic experience is a normal reaction towards an abnormal event. There have been arguments as to the appropriateness of "pathologizing" normal emotional processing of the traumatic reactions. Despite the argument that normal transient stress reactions should not be classified as pathological, the diagnosis of acute stress disorder (ASD) somehow made its way into the DSM-IV nomenclature. ASD shared a number of similar diagnostic criteria with PTSD, but differs from PTSD on time-line, and on emphasis of dissociative symptoms. ASD will be diagnosed if the disturbance lasts for a minimum of two days and a maximum of four weeks, after which a diagnosis of PTSD could be made (American Psychiatric Association 1994).

The entrance of the ASD diagnosis into DSM-IV was prompted in part by a humane, if not political, consideration that distressed victims should not need to wait 1 month before a diagnosis is made and treatments given. There have been serious criticisms on the validity of the ASD diagnosis, especially its emphasis on dissociative symptoms (Bryant and Harvey 2000a, 2000b; Harvey and Bryant 1998, 1999, 2000, 2002). The role of dissociative symptoms in predicting PTSD remains contentious. On the one hand, some workers believe that dissociation reflects pathological cognitive avoidance that impedes emotional processing and recovery from trauma. On the other hand, however, it has been argued that dissociation during a traumatic experience may serve a protective function by attenuating the emotional impact of trauma (Horowitz 1986). Moreover, Creamer, O'Donnell, and Pattison (2004) found that the dissociative symptoms that form the core of ASD were rarely endorsed and showed high specificity but low sensitivity, resulting in a high proportion of false negative diagnoses. They thus concluded that the low sensitivity of the ASD diagnosis renders it a poor screening test for use in identifying high-risk individuals for early intervention and prevention strategies.

Risk Factors of PTSD

The diagnostic criteria for posttraumatic stress disorder in DSM-IV (American Psychiatric Association 1994) make it one of the few disorders in which an aetiological factor is implicated, i.e. direct or vicarious exposure to a traumatic event with feelings of intense fear, helplessness or horror. The diagnostic criteria somehow lured clinicians into focusing their attention on the nature and intensity of the traumatic event, and lost sight of the importance of cognitive appraisal of that particular event by that particular individual. How distressed a victim was during the trauma, or how threatened the person felt has often predicted PTSD better than objective measures of stressor magnitude such as event intensity or extent of bodily injury (Ehlers, Mayou, and Bryant 1998). Highly idiosyncratic and excessively negative appraisals distinguish well between trauma survivors with and without PTSD currently; as well as between survivors who are and are not likely to develop PTSD in the future (Foa, Ehlers, Clark, Tolin, and Orsillo 1999). There is also evidence to suggest that negative appraisals assessed within 4 months post-trauma would predict PTSD symptom severity among survivors 6 months and 9 months down the line (Dunmore, Clark, and Ehlers 2001).

Salient risk factors for PTSD among people exposed to trauma include both variables operative prior to the trauma (e.g., high vs. low cognitive ability) and variables that come into play post-trauma (e.g., high vs. low levels of social support). In general, people are at a higher risk of developing PTSD after a traumatic event if they are already suffering from anxiety or mood disorders, or those with a family history of such disorders. Other risk factors include previous exposure to trauma such as physical or sexual abuse during childhood, low intelligence, high neuroticism, and poor social support (McNally, Bryant, and Ehlers 2003).

With such information at hand, healthcare workers should use these indices as alerts for potential risks in PTSD development, and take appropriate steps in mobilizing social and psychological support when needed.

A Cognitive Model of Persistent PTSD

Notwithstanding the fact that a sizeable proportion of trauma victims will recover from their initial symptoms of stress responses in the ensuing weeks or months even without treatment, there remains a subgroup of individuals whose symptoms may persist for months and years. This subgroup of people with persistent PTSD often suffer impairment in their social and occupational functioning, thus warranting effective treatment for this debilitating disorder.

Ehlers and Clark (2000) proposed a cognitive model of persistent PTSD which has both inspired and informed ways of managing and treating the disorder through a cognitive behavioural framework. The immediate theoretical dilemma is that PTSD is classified in DSM-IV as a form of anxiety disorder, implicating that it is the result of appraisals relating to impending threat. However, PTSD is a disorder resulting from an event that has already happened. To conciliate the puzzle, Ehlers and Clark (2000) suggested that persistent PTSD occurs only if individuals process the traumatic event and/or its sequelae in a way which produce a sense of serious current threat. It was assumed that, unlike individuals who recover naturally, individuals with persistent PTSD are unable to see the trauma as a time-limited event that does not have global negative implications for their future.

Once activated, the perception of current threat is accompanied by intrusions and other re-experiencing symptoms; symptoms of arousal; and strong emotions, such as anxiety, anger, shame or sadness (Clark and Ehlers 2005).

The model proposes that there are two interacting and mutually influencing key processes that lead to a sense of current threat.

First, it was suggested that the nature of trauma memory in people with PTSD is essentially different from the usual autobiographical memories. In its normal state, autobiographical memories are organized and elaborated in a way that facilitates intentional retrieval and inhibits cue-driven re-experiencing of a past event. When recalled intentionally, the autobiographical event contains both specific information about the event itself and the associated contextual information that the experience was in the past. Ehlers and Clark (2000) proposed that trauma memories of people with PTSD do not have this level of organization and elaboration with inadequate integration into their context. Their intentional recall is fragmented with missing details, and they have difficulty recalling the exact temporal order of events. Moreover, there is also a high frequency of involuntary triggered intrusive memories involving re-experiencing aspects of the event in a very vivid and emotional way. Such disorganized trauma memories fuelled by involuntary triggers results in strong emotional arousal and thought intrusions. Such sensory impressions are experienced as if they were happening right now rather that being memories from the past, and the resultant emotions accompanying them are as vivid and as intense as those emotions experienced at the time of trauma.

Second, the negative appraisal of trauma and/or its sequelae determine whether persistent PTSD develops. Individuals may over-generalize from the event and, as a consequence, perceive a range of normal activities as more dangerous than they really are. They may also exaggerate the probability of further catastrophic events in general and take the fact that "I attract disaster" (Clark and Ehlers 2005). Such negative appraisal barred them from seeing the trauma as a time-limited terrible experience that does not necessarily have threatening implications for their future. With this sense of impending threat, strong emotional arousals and intrusive thought are elicited.

Ehlers and Clark (2000) further proposed that the negative appraisals and heightened emotional reactions prompted a series of dysfunctional cognitive and behavioural responses that have the short-term effect of reducing distress such as avoidance, engaging in safety behaviours, or deliberate suppression of intrusive thoughts. However, such dysfunctional behavioural and cognitive strategies have the long-term consequence of preventing cognitive change and therefore maintain the disorder (Clark and Ehlers 2005).

The original Ehlers and Clark (2000) model has received encouraging empirical support for its postulations (Clark and Ehlers 2005). Based on the model, a cognitive therapy programme for PTSD was developed (Ehlers et al. 2005). As predicted by the cognitive model, good treatment outcome was related to greater changes in dysfunctional post-traumatic cognitions. The following paragraphs recap the therapeutic implications of the Ehlers and Clark (2000) model for PTSD which consists of three main therapeutic goals.

Goal 1: Modify excessively negative appraisals of the trauma and its sequelae

Negative appraisals of the traumatic event are identified by careful questioning, particularly about the meaning of what Ehlers et al. (2005) referred to as “hot spots”, i.e. moments of greatest distress in the trauma memory. It has been suggested that “hot spots” can be identified by examining the content of intrusions (Ehlers et al. 2002) and by a probe imaginal reliving (Foa and Rothbaum 1998). Socratic questioning and other general cognitive therapy techniques are then used to modify the negative appraisals. Once the patient has identified a compelling alternative appraisal, the appraisal will then be actively incorporated into the trauma memory by adding it to a written account and holding the new appraisal and the “hot spot” in mind simultaneously when reading out the narrative. The new appraisal can also be inserted into a subsequent imaginal reliving. If introducing corrective information into the trauma memory by verbal means is insufficient, it may need to be augmented by actions or imagery techniques. Because of the disjointed recall of the trauma in PTSD individuals, sometimes it is useful to link the “hot spots” with updated knowledge about the course of the event. A good example of the procedure is provided in Ehlers et al. (2005).

Goal 2: Reduce re-experiencing by elaboration of the trauma memories and discrimination of triggers

In this treatment procedure, the therapist helps the patient develop a coherent narrative account, which starts before the trauma begins, and ends after the patient is safe again. By doing so, the patient is helped to place the series of events during the trauma in context, in sequence, and in the past (Ehlers et al. 2005). This elaboration of the autobiographical memory for the event is not only important for identifying and modifying excessive negative appraisals, but is also thought to inhibit cue-driven retrieval of intrusive memories. This can be achieved through three main techniques: writing out a detailed account of the event, imaginal reliving of the event, and revisiting the site.

Discrimination of triggers usually involves two stages. First, careful analysis of where and when intrusions occur is used to identify the triggers. Second, the link between the triggers and the trauma memory is intentionally broken by differentiating between "then" and "now". Sometimes, it may also be useful to transform imageries into visible and measurable parameters such as actual distance between the person and injurious items.

Goal 3: Drop dysfunctional behaviours and cognitive strategies

Engagement in dysfunctional behaviour such as avoidance may have the temporary effect of reducing one's current sense of threat, but it has the long-term effect of maintaining the PTSD by preventing elaboration of the trauma memory and reappraisal. Dysfunctional cognitive strategies such as wilful suppression of intrusive thoughts will only result in subsequent rebound of the intrusion. Treatment usually starts by discussing the problematic consequences of the dysfunctional behavioural and cognitive strategies, then looking at any ways of dropping or reversing them in the context of behavioural experiments.

Results from four randomized controlled trials and two audits of National Health Service clinics indicate that the treatment is highly effective and acceptable to patients (Ehlers et al. 2003, 2005; Clark and Ehlers 2005).

Cognitive Behavioural Therapy for PTSD

Harvey, Bryant and Tarrier (2003) reviewed current approaches to the treatment of PTSD and CBT has proven to be a safe and effective treatment for the disorder. They have identified that the treatment components that typically constitute CBT for PTSD are psychoeducation, exposure, cognitive restructuring, and anxiety management. They posited that information about common symptoms following a traumatic event will help to normalize trauma reaction, thus helping the patient to develop a formulation of their symptoms and to establish a rationale for treatment if needed. Exposure with response prevention (ERP) either in imagination or in real life for prolonged periods has been found to be helpful as the mainstay of PTSD treatment. However, the actual therapeutic mechanisms underlying ERP still remain unclear, e.g., whether it promotes habituation, or promotes belief correction, or impedes negative reinforcement of avoidance behaviour, or enhances self-mastery through management of the exposure exercise. Cognitive restructuring targets faulty appraisals which have been considered as the major aetiology and maintaining factors of PTSD (Ehlers and Clark 2000). Cognitive restructuring involves teaching patients to identify and evaluate the evidence for negative automatic thoughts, as well as helping patients to evaluate their beliefs about the trauma, the self, the world, and the future (Marks, Lovell, Noshirvani, Livanou, and Thrasher 1998). Anxiety management strategies such as stress inoculation, relaxation and psychoeducation will help patients attain a sense of mastery over their fear, to reduce arousal levels, and to assist the individual when engaging in exposure to the traumatic memories.

In a scholarly review of the efficacy of CBT on PTSD, Harvey, Bryant and Tarrier (2003) rightly considered that different types of traumatic events can vary in terms of chronicity, the degree of violation of an individual's assumption of safety, and the context in which the trauma and recovery occur. In consequence, they did a review based on trauma type such as assault, mixed trauma, terrorism, road traffic accidents, combat veterans, refugees, childhood abuse, and so on. Other studies have also pointed to the general acceptability of evidence-based intervention strategies for PTSD (Tarrier, Liversidge, and Lynsey 2006; Zoellner, Feeny, Corhran, and Pruitt 2003).

Based on the available research evidence on efficacious and effective treatments for trauma stress in victims (Bisson et al. 2004; Bryant 2007; Bryant, Moulds, and Nixon 2003; Ehlers et al. 2003; NICE 2005), the following protocol for managing trauma-affected persons is recommended in our local context:

1. No compulsory single-session CISD either in group or individual format should be carried out for people affected by traumatic events because evidence has shown that CISD impedes natural recovery from the psychological trauma, and victims will fare worse after CISD than without CISD. "Watchful waiting" (NICE 2005) is the key axiom.
2. For those individuals who are troubled by initial stress symptoms, support, reassurance, normalization, and non-specific psychological first aid should be provided without over-emphasizing the specifics of ASD or PTSD symptoms.
3. Based on the evidence that much adaptation occurs in the initial weeks after exposure, identification of high risk individuals is more accurate when the initial distress has subsided. For mild symptoms that have been present for less than 4 weeks, watchful waiting only should be considered. If needed, a follow-up contact within 1 month after the watching period should be arranged.
4. Individuals who are at high risk for developing PTSD should be targeted; and treatment should only be offered after careful assessment whereby high risk is determined.
5. For those with severe posttraumatic symptoms or with severe PTSD in the first month after the traumatic event, trauma-focused CBT should be offered. These treatments should normally be provided on an individual outpatient basis.

6. For those with severe and persistent PTSD, trauma-focused CBT or eye movement desensitization and reprocessing (EMDR) should be offered. Again, these treatments should be provided on an individual outpatient basis.
7. The key components of CBT should be psychoeducation, exposure, cognitive restructuring and anxiety management. Where appropriate, cognitive therapy based on the Ehlers and Clark (2000) model should be used to tackle negative appraisal, faulty traumatic memories, misidentification of triggers, and using dysfunctional behavioural and cognitive strategies in dealing with traumatic stress symptoms.
8. For high-risk individuals, consideration should also be made in working along-side with psychiatric experts in PTSD. In patients who refuse psychiatric care, administration of b-adrenergic blockers or low-doze anxiolytics may be considered as a way of reducing symptom severity although research has found no significant impact on the incidence of developing PTSD despite early psycho-pharmacological intervention (Cahill, Prins, Weber, and McGaugh 1994; Pitman, et al. 2002; Vaiva et al. 2003).

Social and Political Factors in Trauma Management

Like its Western counterparts, Hong Kong has gone through a period of assertive psychological intervention for trauma victims using a crisis intervention or CISD format initiated originally by Mitchell (1983) and later exemplified by Everly and Mitchell (1999). Clinicians were lured into this early intervention format by its *prima facia* sensibility of normalization, support and ventilation. Their commitment to this intervention format was further reinforced by the illusion that timely provision of CISD could prevent the development of PTSD in the future. It has not been until the last decade that information and research evidence has proven to us that the original assertions of Mitchell and Everly were unfounded. Rather than producing no therapeutic effect to victims of trauma, CISD has further been proven to be potentially harmful because it impedes natural recovery of psychological trauma. As clinicians, we have to abide to the professional credo of *primum non nocere* ("first do no harm"), and reposition our delivery of interventions in accordance to current knowledge and practices (Lilienfeld 2007).

The DSM-IV diagnosis of acute stress disorder (ASD) may spark further debates and revisions based on its time-limited validity, and on its emphasis on dissociative symptoms which has shown to be poorly related to PTSD. Further, the diagnosis of ASD may have unwanted implications in forensic work if compensations were awarded on the basis of this transient condition.

For governments and institutions, it was originally thought that they would be seen as doing something useful and immediate for victims of trauma, otherwise they would be construed as inefficient and nonchalant. Some employers might be wary of the possibility of lawsuits that may be levied against them for not providing psychological first-aid to victims afflicted with traumatic events. Experience of the 9/11 terrorist attack in New York City, however, has proven to us that the actual need for crisis intervention or CISD was greatly overestimated; and experts have seriously underestimated the resilience of the average citizens (Kadet 2002; McNally, Bryant, and Ehlers 2003). The negative effects of over 9,000 grief and crisis counsellors descending upon New York City has still not been documented. Indeed, it would become a political scandal if proofs have emerged that the well-intended CISD teams have in fact impeded natural psychological recovery in the victims that they have served. Given the overwhelming evidence that CISD has been classified as a "potentially harmful therapy" (Lilienfeld 2007), lawsuits may, in the end, turn the other way. That is, employers or institutions or even governments may be sued for providing an intervention strategy that would impede natural recovery of their traumatized employees from psychological trauma.

The analogy is that of a car designed to facilitate efficient transportation of its passengers. If, after a series of irrefutable laboratory testings, the car is found to be potentially hazardous to its passengers, there should be no alternative to the manufacturer but to effect an immediate factory recall of all such cars produced and have their defects rectified. Perhaps it is high time in Hong Kong for clinicians to instigate a factory recall of all CISD procedures *á la* Mitchell (1983), and re-train front-line workers such as crisis counsellors, educational psychologists and clinical psychologists in the most current knowledge and practices promulgated by authorities of good practice guidelines (e.g. NICE 2005).

The bulk of clients suffering from trauma are not victims of large-scale civil disasters, but common individuals in everyday life who have undergone traumatic experiences as a result of assault, motor vehicle accidents, illness, violence, abuse or grief (Ehlers 2006; Ehlers, Mayou, and Bryant 1998; Joycox, Zoellner, and Foa 2002; Tedstone and Tarrier 2003). This is where resources should concentrate in order to benefit those really in need.

Conclusion

This chapter critically reviews current work with trauma victims in the local context, and discussed evidence against the usefulness of early intervention strategies such as crisis intervention or critical incident stress debriefing (CISD). Clinicians should be mindful of the potential resilience of the average person in face of traumatic events, and care should be taken not to impose any intervention strategies that may impede this natural recovery process. The usefulness of the acute stress disorder (ASD) diagnosis and risk factors for posttraumatic stress disorder (PTSD) were discussed. Following the cognitive model of PTSD by Ehlers and Clark (2000), cognitive behavioural therapy (CBT) for PTSD was elaborated and their effectiveness reviewed.

Based on the available research evidence on efficacious treatments for trauma stress in victims, a protocol for managing trauma-affected persons is proposed for adoption in our local context. Alluding to social and political considerations, it was further argued that all current work on early psychological intervention for trauma-afflicted persons should be reviewed. As scientist-practitioners, clinicians are charged with the duty to re-examine the work they are doing, as abide to the basic ethical principle of *primum non nocere*.

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4

Psychopharmacology for the Psychologically Traumatized Patients

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- Whereas at present a largely empirical approach is adopted for the psychopharmacotherapy of the psychologically traumatized patients (i.e. using medications initially developed as antidepressants, anxiolytics, anticonvulsants, antipsychotics, etc), in the future a more rational approach will be used.
- Potentially useful medications in future will consist of agonists of neuropeptide Y, serotonin, opioid, NMDA/glutamine, BDNF, insulin-like growth factor-1 and GABA; and antagonists of corticotropin-releasing factor, catecholamines, substance P, cholecystokinin and kindling mechanisms.
- Predictors of response to pharmacotherapy include being male, young, and having multiple traumatic events, combat-related trauma, and no dissociative symptoms.

There are 2 approaches of psychopharmacotherapy for the psychologically traumatized patients:

- Empirical Approach — Try various classes of currently available psychotropic drugs on the traumatized patients, and assess their effects empirically.
- Rational Approach — Study the neurobiological basis of the human stress response, and propose specific drug treatments in a logical manner to tackle each of those neurobiological abnormalities.

Empirical Approach

Pharmacological strategies that may be beneficial to the postdisaster patients include: (i) anxiolytics, (ii) antidepressants, (iii) antipsychotics, (iv) anticonvulsants, (v) hypothalamic-pituitary-adrenal (HPA) agents (corticotropin-releasing factor [CRF] antagonists and glucocorticoids), (vi) opioids, and (vii) other compounds, including neuroleptide Y agonists and cholecystokinin antagonists. Each of these will be presented in turn.

Anxiolytics

Anxiolytics include (1) ß-adrenergic antagonists, (2) α_2–adrenergic agonists, (3) α_1–adrenergic antagonists, (4) benzodiazepines, (5) non-benzodiazepine sedative-hypnotics, (6) ethanol.

(1) ß-Adrenergic blockers (e.g., propranolol)

According to much research in the field of memory, declarative memory (memory about events) and emotional memory operate in parallel (Le, Doux 1996). Researchers have found that the intensity of the adrenergic output may foster emotional learning at the expense of declarative memory, thus tilting the balance toward the amygdala (Pitman, Shalev, and Orr 2000; Lupien and Lepage 2001). In a randomized, double-blind, placebo-controlled trial, normal participants received propranolol (a nonselective ß-adrenergic antagonist with effects at both ß$_1$ and ß$_2$ receptors) or placebo before viewing slides of either neutral or emotionally stressful scenes (Cahill, Prins, Weber, and McGaugh 1994). One week later, the participants were recalled for a surprise memory exam. Those who received the placebo recalled the emotionally loaded slides much better than the neutral slides, while those who received propranolol recalled both sets equally. The study was modified 4 years later and used a third arm consisting of nadolol (a ß-adrenergic antagonist that does not cross the blood-brain barrier). As there has been evidence for postlearning and retrograde memory enhancement with administration of beta-adrenergic agonists (Cahill, Pham, and Setlow 2000), this study employed a different dosing method, giving the medications 1 to 3 hours after viewing the slides (Van Stegeren, Everaerd, Cahill, McGough, and Gooren 1998). In this trial, nadolol was equivalent to placebo, while the propranolol group behaved as before. Other trials have shown impairment of retrograde emotional memories with systemic administration of a ß-adrenergic blocker up to 24 hours after the task.

Following theories related to a dysregulated noradrenergic system in the peri- and posttraumatic periods, and the fact that antiadrenergic medications have been recommended for the treatment of chronic posttraumatic stress disorder (PTSD), two studies have looked at propranolol's effect in preventing PTSD. A randomized double-blind pilot study in 2002 gave accident victims propranolol 40 mg four times daily starting within 6 hours of the trauma and continued treatment for 10 days (Pitman et al. 2002). At 1- and 3-month follow-up assessments, there was no difference in PTSD symptom scores between the two groups. The group that received propranolol, however, demonstrated significantly less psychophysiologic reactivity (e.g. heart rate, skin conductance) when asked to perform mental imagery related to the trauma. The other study gave propranolol 40 mg three times daily for 7 days followed by an 8- to 12-day taper (decreasing by

40 mg every 4 days) to victims of motor vehicle accidents or assaults within the last 2 to 20 hours (Vaiva et al. 2003). Inclusion criteria specified having a heart rate over 90, signifying a likely hyperadrenergic state. At 2-month follow-up, the rates of PTSD in the control group (3 of 8 patients, 37.5%) exceeded those in the propranolol group (1 of 11 patients, 9.1%), a difference also reflected in PTSD symptom scores.

Following preclinical evidence that propranolol may allow even greater stress-related emotional memory impairment after reactivation trials or re-exposure to stimuli than when administered immediately after an initial training session (Przybyslawski, Roullet, and Sara 1999), another group looked at propranolol for preventing the re-emergence of PTSD after a subsequent trauma (Taylor and Cahill 2002). In this case report, a nurse with a history of PTSD after each of five motor vehicle accidents in the last 10 years received propranolol at a dose of 60 mg twice daily within 48 hours after her sixth accident. Although her original PTSD course was chronic and somewhat difficult to treat, her symptoms had remitted before this sixth accident. She once again became acutely symptomatic in the aftermath, however. Within 48 hours of having received the medication, she reported a subjective improvement in symptoms. Of note, 2 months post-trauma, she ran out of propranolol, and within 5 days she experienced a rapid re-emergence of symptoms, which again was brought under control by recommencing the medications. Of course, this may represent a placebo response.

It is unknown whether propranolol is in fact effective in preventing PTSD, and if so, at what dose and in what time period; researchers debate the time course for memory consolidation, from hours to days or even weeks (Seidenbecher, Reymann, and Balschun 1997; Sacchetti, Lorenzini, Baldi, Tassoni, and Bucherelli 1999). Longer and larger trials are necessary. The promising evidence for its efficacy, however, together with its limited adverse effect profile, makes its use in the postdisaster setting clinically possible. The same qualifications, however, apply to this and every other drug mentioned; the ability to use a medication should not preclude other clinical and therapeutic skills.

(2) α_2-adrenergic agonists (e.g., clonidine, guanfacine)

(3) α_1-adrenergic antagonists (e.g. prazosin)

Clonidine is an agonist at noradrenergic α_2 receptors normally used for the treatment of hypertension, opiate withdrawal, and impulsive and aggressive behaviour. In cases of chronic PTSD, clonidine has been shown to reduce symptoms of hyperarousal, hypervigilance, nightmares, irritability, and aggressiveness (Morgan, Charles, Krystal, and Southwick 2003; Kinzie and Leung 1989; Kolb 1991). Clonidine has been shown to improve pre-frontal cortex (PFC) functioning by activating presynaptic α_2-receptors, thus decreasing norepinephrine (NE) release and minimizing the NE available to bind to α_1. It thereby facilitates the PFC-mediated inhibition of irrelevant and distracting sensory information, the provision of inhibitory feedback to the amygdala, and task-oriented working memory and concentration (Arnsten 1998). Guanfacine works similarly and has the same effect, but with a less sedating and hypotensive adverse effect profile (Horrigan 1996). Prazosin is an antagonist at α_1-receptors and has been shown to reduce nightmares in chronic PTSD (Raskind 2003). Theoretically, it also should improve PFC function by blocking α_1, but as it does not affect α_2, it would not inhibit the release of NE. The paucity of evidence prohibits the author from making definitive recommendations regarding the use of these agents in the immediate disaster period.

(4) Benzodiazepines (e.g., lorazepam, clonazepam, alprazolam)

Benzodiazepines function as anxiolytic agents by potentiating and prolonging the actions of gamma-aminobutyric acid (GABA) by increasing the frequency of GABA-mediated chloride channel openings (Study and Barker 1982). Benzodiazepine receptors are distributed widely throughout the brain at cortical and subcortical regions, although most are in the cortical gray matter (Charney and Drevets 2002). Benzodiazepines reduce the firing rate of the locus caeruleus (LC), theoretically reducing symptoms of hyperarousal, intrusive memories, and excessive startle response, and benzodiazepines often are used by patients with PTSD to cope with their symptoms (Charney and Drevets 2002). Patients with PTSD and animals exposed to inescapable stress show a reduction in the number and functionality of benzodiazepine receptors in their PFC (Bremner et al. 2000; Lippa et al. 1978; Weizman et al. 1989). One study found up to a 41% decrease in the distribution volume of benzodiazepine receptor binding at the PFC in combat veterans with PTSD (Bremner et al. 2000). Some double-blind placebo controlled studies, however, have shown that these medications are not effective in chronic PTSD. A randomized, double-blind crossover trial of 10 participants compared alprazolam with placebo, each for 5 weeks, in chronic PTSD (Braun, Greenberg, Dasberg, and Lerer 1990). There was a modest improvement in anxiety symptoms in the alprazolam group, but PTSD-specific symptoms were unaltered. Of course with the small sample size, a Type II error cannot be ruled out.

There have been a few studies that have looked directly at using benzodiazepines in the acute period with the hope of preventing PTSD and ameliorating current acute symptoms. One study included 13 trauma survivors who received either clonazepam (n = 10, dose = 2.7 +/- 0.8 mg/d) or alprazolam (n = 3, dose 2.5 mg/d) within 6.7 ± 5.8 days of their trauma (Gelpin, Bonne, Peri, Brandes, and Shalev 1996). The participants were matched with controls for age, gender, and symptomatology. At 1- and 6-month re-evaluations, there was no significant difference in their anxiety scores, but after 6 months, nine participants who received benzodiazepines had developed PTSD, compared with only three controls. The authors thus concluded that early and prolonged use of benzodiazepines after a trauma can increase one's risk of developing PTSD. Explanations for this unexpected finding included possible impairments in one's ability to experience levels of arousal necessary for therapeutic extinction to occur (Walker and Davis 2002). Also contributing may be the context surrounding the medication use and the neurochemical environment it establishes in the brain. For example, when a benzodiazepine is given at the time of extinction learning, the fear of the conditioned stimulus (CS) returns when future testing is done in the absence of the benzodiazepine (Bouton, Kenney, and Rosengard 1990). Pretreatment with a benzodiazepine before stress, however, can block stress-related increases in NE turnover at the cortex, hippocampus, hypothalamus, LC, and amygdala (Drugan, Ryan, Minor, and Maier 1984; Grant, Huang, and Redmond 1980), producing an anterograde amnesia (Tomaz et al. 1993). Additionally, as benzodiazepines do not seem to cause retrograde amnesia, they ideally should be given before the traumatic experience (Nutt 2000). This is obviously impossible in most cases, but there are exceptional circumstances when a trauma is known and expected. As always, one must be sure that the medication will not impede one's ability to survive the acute period. At this time, while it is not known what to do when a person was taking a benzodiazepine before the disaster, it seems prudent to continue the medication to avert any increases in arousal or anxiety (Owens, Vargas, Knight, and Nemeroff 1991).

There are few data on the use of benzodiazepine hypnotic medications in the immediate aftermath of a trauma. An uncontrolled pilot study of temazepam for acute stress symptoms (not necessarily meeting criteria for acute stress disorder [ASD]) included four participants, of whom two had a prior history of major depressive disorder (though in remission for at least 6 months) (Mellman, Byers, and Augenstein 1998). Participants were identified within 1 to 3 weeks of their traumatic event and started on a regimen of temazepam, 30 mg at bedtime for 5 days followed by 15 mg at bedtime for 2 days. Evaluations 1 week after medication cessation showed improved sleep and reduced symptoms of posttraumatic stress. The authors note that the facilitation of a normal sleep pattern (thereby regulating hyperarousal) before the consolidation of the neurobiology of PTSD may be important in preventing progression to the chronic form of the illness.

Benzodiazepine administration can be considered in the immediate postdisaster setting for acute symptoms of extreme arousal, insomnia, and uncontrollable anxiety, all of which may be considered to be greater risk factors for developing PTSD than the administration of the medications. Importantly, they should be used only for a short period.

(5) Nonbenzodiazepine sedative hypnotics (e.g., zolpidem and zopiclone)

Intact sleep has been theorized to have a restorative function. It provides improved resiliency after disasters, helps with coping in the face of rapidly changing situations, and facilitates emotional integration of stressful events (dreaming and rapid eye movement sleep may play a role in integrating emotionally distressing memories) (Cartwright, Kravitz, Eastman, and Wood 1991; Task Force on Psychiatric Dimensions of Disaster 2004). Sleep imbalance not only may put the person directly at risk for postdisaster trauma-related sequelae, but also for alcohol abuse, an entity that independently impedes recoding of traumatic memories (White 2001). However, the mainstay of treatment, appropriate sleep hygiene, may not be possible or even practical during a disaster or in the postdisaster period, and many disaster victims report sleep disturbances (Lavie 2001). Still, it should be noted that subjective impairment tends to contrast with objective findings. Thus, one's level of subjective distress should be analyzed in the context of the person's overall level of functioning and symptomatology.

Even so, underscoring the importance of sleep, experts recommend that in a traumatic setting, sleep be viewed and treated as an independent entity. Although it may not necessarily imply or mark the presence of some greater or more profound psychiatric condition, it should, nonetheless, be treated appropriately. The most convincing data for soporific medications in the short-term include those for short-acting benzodiazepines and non-benzodiazepine sedative hypnotics. There is less convincing evidence for antihistamines (e.g. diphenhydramine) and sedating antidepressants (e.g. trazodone and amitriptyline). A significant caveat to this, however, may concern patients with a history of substance abuse or dependence, for whom one of the latter medications may be preferable.

(6) Ethanol

Alcohol use, not abuse or dependence, has been shown in a few studies to actually prevent the development of PTSD after a disaster, especially if the person was drinking before the disaster (McFarlane 1998). A recent study looked at an epidemiological cohort of 127 victims of a ballroom fire 7 to 9 months after the disaster and showed that alcohol consumption and alcohol intoxication each independently decreased the incidence of PTSD (Maes, Delmeire, Mylle, and Altamura 2001). Theories underlying this effect have focused on memory- and arousal-related mechanisms. Much like benzodiazepines, alcohol has attenuating effects on stress-induced increases in NE turnover at the amygdala and the LC (Shirao et al. 1988), thus minimizing symptoms of peritraumatic anxiety and arousal. This may inhibit the storage of memories and subsequent fear conditioning by inhibiting encoding, consolidation, or retrieval of previously conditioned or contextually related traumatic memories (Maes, Delmeire, Mylle, and Altamura 2001). Further, alcohol potentially inhibits N-methyl-D-aspartate (NMDA)-mediated synaptic channels at the amygdala, thus directly inhibiting long-term potentiation (LTP) (Calton, Wilson, and Moore 1998; Faingold, N'Gouemo, and Riaz 1998).

Drinking alcohol after a disaster is not advised, however, and studies have shown an increase in pathological alcohol use postdisaster. After a traumatic disaster, alcohol use may inhibit the necessary and healthy recoding of memories in the same manner as benzodiazepine use. Just what amount of alcohol consumption would be pathological versus anxiety-reducing in the postdisaster period is unknown, however. And, the author cannot recommend chronic consumption of alcohol just to be ready in case a disaster strikes.

Antidepressants

Serotonin reuptake inhibitors (SRI) are among the most effective medications for the treatment of PTSD, depression, and a host of other mood and anxiety disorders. Although they have been largely theorized to work by means of their actions on the serotonin system, several additional effects have been found. As mentioned previously, all therapeutically active antidepressants effectively reduce levels of CRF. Further, they have been shown to increase neurogenesis in the adult hippocampus after 2 to 4 weeks, corresponding to the time course of their clinical antidepressant effect. For example, fluoxetine reversed impaired neurogenesis when administered after repeated footshock-induced stress in animals (Duman, Nakagawa, and Malberg 2001). The evidence of increased adult neurogenesis by antidepressants in the human brain, however, is more indirect, and consists of changes in the hippocampal volume as measured in radio-imagery, etc. Each of these actions can have beneficial effects on the progressive neurobiological courses of PTSD or major depressive disorder. Additionally, as these medications treat the full-blown chronic conditions, a powerful preventive effect is possible (Task Force on Psychiatric Dimensions of Disasters 2004).

Several studies have shown some cause for optimism in this regard. Fifteen burn victims were treated with citalopram for 6 months, and none developed PTSD, compared with 50% of controls (Blaha, Svobodova, and Kapounkova 1999). A prospective, randomized, double-blind study compared a 7-day trial of imipramine versus chloral hydrate in 25 pediatric (2 to 19 years old) burn victims suffering from acute stress disorder (ASD) (Robert, Blakeney, Villarreal, Rosenberg, and Meyer 1999). Outcome measures assessed symptoms of acute stress disorder: 10 of 12 (83%) patients responded to low-dose imipramine, whereas 5 of 13 (38%) patients receiving chloral hydrate experienced a reduction in symptoms. The typical course of pharmacotherapy lasted approximately 6 months, and discontinuation of the medication at this time did not result in a re-emergence of symptoms. When the nonresponders who received chloral hydrate were switched to imipramine after the study, seven of eight patients experienced a decrease in symptoms.

It is difficult and perhaps premature to recommend prescribing antidepressants for the treatment of ASD or the prevention of pathological sequelae. *If a patient presents with strong depressive symptoms in the aftermath of a trauma or disaster however, it may be reasonable to offer these treatments* (especially as depressive symptoms themselves are independently correlated with the emergence of PTSD). Follow-up is crucial and oftentimes not available in the chaotic disaster milieu, however. Of note, dosing recommendations often call for a "start low, go slow" method, as patients with anxiety disorders are hypersensitive to the anxiogenic effects initially produced by the SRIs (National Center for PTSD 2003).

Antipsychotics

Though the use of antipsychotic agents for psychosis in disaster settings is justified, as may be their use in chronic PTSD, to the author's knowledge there have been no randomized, double-blind, placebo-controlled studies on their use in preventing disaster-related sequelae such as exacerbations of pre-existing conditions or new onset of mood, anxiety, or psychotic disorders. It should be mentioned at this point that patients with dissociation frequently can present similarly to those suffering from psychosis; it is common for dissociating patients to hear internal voices, to be disoriented, to experience rapidly alternating mood shifts, and to demonstrate cognitive and attentional difficulties (Nijenhuis, van der Hart, and Steele 2002). Thus, one must be phenomenologically diligent before chalking up someone's response to either of these entities. Also, an additional word of caution when treating patients from divergent cultural backgrounds; oftentimes what appears as psychosis to a Western treater may be culturally sanctioned behaviour or may be merely a heretofore previously not confronted symptom of nonspecific distress (Olfson et al. 2002).

There are some reports in the literature describing the use of risperidone to treat ASD. In one case report, four physically traumatized inpatients (without psychiatric histories) were diagnosed with ASD after initially presenting with flashbacks. All were given risperidone (0.5–2 mg daily), which resulted in a marked improvement in these patients' symptom profiles within a few days (Eidelman, Seedat, and Stein 2000). In a retrospective study, 10 burn patients with ASD also were given risperidone (0.5–2 mg daily) and experienced a significantly reduced symptom load in 1 to 2 days after starting the medication (Stanovic, James, and Vandevere 2001).

Recommendations are limited to the acute treatment of psychosis or mania, conditions that usually would require antipsychotic medications. Prophylaxis of psychotic exacerbations in severe and chronic mental illnesses (e.g. schizophrenia) should be managed on an individual basis.

Anticonvulsants

Anticonvulsant medications work in seizure and psychiatric disorders by multiple different mechanisms. Commonalities, however, exist among some in their ability to affect the GABAergic system and in their ability to impede kindling in the brain. The phenomenon of kindling has been theorized to be at work in the formation and persistence of PTSD (Adamec 1997; Friedman 1994; Grillon, Southwick, and Charney 1996). Kindling is marked by progressive neuronal changes emerging after repeated electrical pulse stimulations that individually are too low to produce electroencephalographic or behavioural effects when first experienced. Possibly involving LTP and NMDA receptors, this activity in the limbic system may induce a susceptibility to psychological arousal and give rise to PTSD-like symptoms of intrusive memories, nightmares, and hyperarousal. Theoretically, in PTSD, the repeated activation of conditioned fear memories by an amygdala hypervigilantly scanning the environment for threats produces a kindling-like process and results in spontaneous intrusive memories. The true spontaneity of such intrusive memories is questionable, however, and may be stimulated by something other than kindling.

Although there are no studies of anticonvulsants used to prevent PTSD or other pathological posttraumatic sequelae, a few studies have observed the effects of various anticonvulsants in chronic PTSD (Iancu, Rosen, and Moshe 2002). Carbamazepine acts by blocking kindling and inhibiting noradrenergic arousal in the brain. Valproic acid and related compounds increase GABA activity and the sensitivity of the GABA receptor. Topiramate increases GABAergic transmission and antagonizes glutamate. Lamotrigine inhibits voltage-dependent sodium channels and excitatory amino acids, antagonizes calcium, blocks 5-HT$_3$ receptors, and increases dopamine transmission. Further, lamotrigine has positive effects specifically on symptoms of dissociation (present in ASD and a possible risk factor for the development of PTSD). Ketamine studies have shown that while benzodiazepines reduced some, but not all dissociative symptoms (Krystal et al. 1998), and haloperidol improved cognitive deficits but no other symptoms (Krystal et al. 1999), lamotrigine prevented most of the dissociative symptoms and the cognitive deficits usually induced by ketamine (Anand et al. 2000). Lamotrigine is able to decrease glutamate release directly, and early treatment can possibly retard the establishment of traumatic memories and noradrenergic sensitivity

(Morgan, Charles, Krystal, and Sothwick 2003). It is not clear if lamotrigine has any inhibitory effects on extinction, which requires similar LTP-based mechanisms in the hippocampus.

Lastly, phenytoin also antagonizes sodium channels and blocks glutamate release, and it may have effects in addition to those described for the other anticonvulsants. It has been shown in animals to prevent stress and glucocorticoid-induced atrophy of the hippocampus and block stress-induced remodeling of other regions (McEwen 1999) without any obvious effect on behaviour during and after stress (Watanabe, Gould, Cameron, Daniels, and McEwen 1992).

In summary, not enough is known about the possible effects of anti-convulsants in preventing a pathological progression to PTSD after disaster-related trauma. Although it may seem beneficial to start phenytoin to prevent damage to the hippocampus, the time course, dosing, and indications are relatively unknown, and there are numerous side effects of this medication. The same can be said of lamotrigine, which requires an extremely diligent titration and close follow-up, neither of which may be possible in a disaster setting.

Hypothalamic-Pituitary-Adrenal (HPA) agents

HPA agents include CRF (corticotropin-releasing factor) antagonists and glucocorticoids.

(1) Corticotropin-releasing factor antagonists (e.g., antalarmin and astressin)

With the current level of knowledge regarding stress responses, antagonizing CRF receptors appears to be an ideal place for an intervention; in fact, most clinically effective antidepressants and electroconvulsive therapies (ECT) reduce the activation of CRF-containing neurons (Valentino, Curtis, Parris, and Wehby 1990). Theoretically, one could block the ignition of the adrenergic, neuroendocrinologic, and immunologic cascade.

Several compounds have been synthesized that might block the actions of the excessive levels of CRF that may occur in patients with PTSD (Morgan et al. 2003), some of which are completing phase II trials (Kehne and De Lombaert 2002). CRF-1 receptor antagonists effectively inhibit the behavioural, sympathetic, and neuroendocrine responses to acute stress in rats (Zorrilla, Valdez, Nozulak, Koob, and Markou 2002; Spina et al. 2000) and monkeys (Habib et al. 2000), occasionally even reversing anxiogenic responses to social stress or local CRF infusion. Importantly, even though rats given antalarmin showed a reduction in spontaneous defensive withdrawal behaviours, they maintained the ability to respond to some novel stimuli (Deak et al. 1999).

(2) Glucocorticoids (e.g., hydrocortisone)

Cortisol has a primary role in terminating the acute stress response through its negative feedback effects on the HPA axis and NE release. In disaster victims who do not have any biological alterations reminiscent of chronic stress (e.g. reduced cortisol release, upregulation of glucocorticoid receptors, or enhanced feedback sensitivity), the production of cortisol should turn off the acute stress response. In those with pre-existing homeostatic alterations, however, it is possible that the exogenous administration of glucocorticoids could end the prolonged response, causing a down-regulation of the glucocorticoid receptors (Friedman 2000). One is unsure of the effects this may have on the hippocampus and memory formation, however.

A recent study observed that intensive care patients with septic shock who received stress-dose hydrocortisone for 12 days had significantly less post-stress psychological morbidity than their counterparts who received no glucocorticoids (Schelling et al. 2001). These data were obtained from an ongoing randomized, double-blind placebo controlled study measuring the hemodynamic effects of hydrocortisone on these patients. As part of this extension, they were assessed for PTSD criteria at 21 to 49 months post-intensive care. PTSD developed in 7 out of 11 (63.6%) controls versus one of nine (11.1%) study patients. This suggests a protective effect of exogenous cortisol administration at the time of acute septic shock. The authors theorized that the glucocorticoid-mediated disruption of memory retrieval mechanisms may be the protective factor. Several limitations exist regarding this study, however. Extrapolating to acute stress or trauma is not necessarily warranted. The required absence of a history of psychiatric illness in these patients makes it difficult to apply these outcomes to real-world disaster settings. Finally, not knowing the total doses of benzodiazepines or opiates received further complicates things.

Other studies have shown seemingly opposite effects. Ketoconazole (an inhibitor of steroid synthesis) reduced anxious behaviour commensurate with its reduction of corticosterone levels in rats exposed to cat predators; and it actually abolished the behavioural fear effects when these animals were compared with the control group (Cohen, Benjamin, Kaplan, and Kotler 2000).

Clinical recommendations cannot be made regarding the use of these agents in the disaster setting. If a person is taking a glucocorticoid for a medical condition, however, such therapy should be continued.

Opioids

Opiates have been found to have a counter-regulatory role in the stress response (Morgan et al. 2003). It has been theorized that opiates may attenuate NE and

CRF activity, block arousal-enhanced memory consolidation, and decrease the likelihood of sensitization of the noradrenergic system. There is a high density of μ-receptors at the LC and administration of morphine causes hyperpolarization of the LC, with diminished firing and NE release (Korf, Bunney, and Aghajanian 1974). Further, opiate receptors are colocalized with α_2-adrenergic receptors at the amygdala, providing dual inhibition of this structure (Freedman and Aghajanian 1985). Animal studies of opiate administration have shown a reduction in the activity of amygdalar cells with a decreased response to noxious thermal and mechanical stimuli (Huang, Besson, and Bernard 1993). Additionally, acute uncontrollable footshock in animals has been found to stimulate counter-regulatory increases in endogenous opiate secretion (Madden, Akil, Patrick, and Barchas 1977). Similarly, traumatic reminders in patients suffering from PTSD produce a decrease in pain sensitivity that can be reversed by naloxone (Pitman, van der Kolk, Orr, and Greenberg 1990). In a study of the effect of opiate agonists and antagonists administered after a learning task, agonists produced impairments in long-term memory by decreasing NE release at the amygdala, while antagonists actually increased long-term memory (McGaugh 2000; McGaugh 1989).

Clinically, a recent study showed that doses of morphine sulfate administered to 24 pediatric burn victims (6 to 16 years old) negatively correlated with the degree of PTSD symptoms found at 6 months (Saxe et al. 2001). These findings could not be accounted for by the treatment of concurrent pain.

It seems reasonable to make several suggestions. If a patient is in physical pain or has been physically traumatized (also independent risk factors for pathological psychiatric sequelae), one should not hesitate in treating with opiates. There is not enough evidence, however, for the ad-lib use of opiate medications in the immediate disaster setting.

Other compounds

(1) Neuropeptide Y agonists

Neuropeptide Y (NPY) is a 36-amino-acid peptide (Tatemoto 1982) that essentially functions to inhibit the release of the neurotransmitters with which it is colocalized (Illes and Regenold 1990). It is one of the most prominent neuropeptides in the central and peripheral nervous systems and is colocalized with NE at most sympathetic nervous system terminals (Lundberg, Terenius, Hokfelt, and Goldstein 1983). Additionally, NPY has many interconnections with other neuromodulators in the brain, but most saliently for the present context it reciprocally regulates CRF and NE release in the parts of the brain involved in the appraisal and response to threat (Heilig, Koob, Ekman, and Britton 1994; Kask, Rago, and Harro 1998; Martins, Marras, and Guimaraes 1997; Sheriff et al. 2001).

Many animal and human studies have shown NPY to have significant anxiolytic and resiliency mediating effects (Heilig, Soderpalm, Engel, and Widerlov 1989; Heilig et al. 1993; Broqua, Wettstein, Rocher, Gauthier-Martin, and Junien 1995; Heilig, McLeod, Koob, and Britton 1992), and it is released in proportion to the intensity and duration of the stressful event (Zukowska 1995). An animal study showed that intracerebroventricular administration of NPY reverses the shortening of sleep induced by CRF and psychological stress (Yamada et al. 1996). Further, preclinical work has demonstrated a reduction in the firing rate of the LC with a commensurate reduction in NE and CRF release after an administration of NPY (Heilig and Widerlov 1995). In studies with normal people, NPY release was increased in a variety of stressful conditions and at yohimbine administration (Lundberg et al. 1985; Kaijser, Pernow, Berglund, and Lundberg 1990; Morris et al. 1986; Pernow et al. 1986; Rasmusson, Southwick, Hauger, Charney, and Dennis 1998). NPY release in stressful conditions (a Army Special Forces course, in this case) was positively correlated with plasma cortisol levels, behavioural performance, and ability to interact with the environment, and negatively with subjective distress. Further, those participants who succumbed to the stress of the course failed to refresh their NPY supply 24 hours later, perhaps manifesting a depletion of this regulatory peptide (Morgan et al. 2000; Morgan et al. 2001; Morgan et al. 2002). Patients with PTSD frequently have reduced NPY at baseline and show a blunted release of NPY after yohimbine infusion or in response to subsequent stressors (Rasmusson et al. 2000). Thus, a diminished capacity for NPY production modulating NE may be a neurobiological risk factor for PTSD. Although there are, to the author's knowledge, no studies looking at the administration of NPY in any psychiatric conditions, it has been found that long-term lithium exposure counteracted the effect of deficient baseline NPY in adult animals that were subjected to early maternal deprivation (Husum and Mathe 2002). In fact, lithium both raised levels of NPY and reduced those of CRF. What this means clinically is uncertain, but it looks promising. Again, medications that would fit into this category are not available for clinical prescription.

(2) Cholecystokinin antagonists

Cholecystokinin (CCK) is an anxiogenic neuropeptide that is found throughout the body; in the CNS it is located primarily in the cortex, hippocampus, amygdala, periaqueductal gray, substantia nigra, and raphe nuclei (Charney and Drevets 2002). A study of healthy humans showed that pentagastrin, a CCK-B agonist, produced significant, extreme, and rapid increases in ACTH and cortisol levels, and increased heart rate, blood pressure, and anxious distress (Tsutsumi et al. 2001). Agonists also produce increases in the amplitude of eye-blink startle compared with placebo, as well as increases in anxiety and heart rate, followed by fatigue (Shlik, Zhou, Koszycki, Vaccarino, and Bradwejn 1999). Further, studies with rats have led to theories that the CCKergic system in the hippocampus is involved in stress-induced impairments in spatial recognition memory (Dauge, Pophillat, Crete, Melik-Parsadaniantz, and Roques 2003). Although definitive mechanisms for these actions are unknown, it is becoming clear that CCK can activate the HPA axis pharmacologically by a different route than that mediated by CRF, especially as activation by means of CCK is relatively resistant to feedback from cortisol (Abelson and Young 2003). Previous chronic stress facilitates the release of CCK in the brain (Bhatnagar et al. 2000; Kim et al. 2003), and studies have found that patients with PTSD are more sensitive to the anxiogenic effects of CCK-4, (an agonist) than are normal controls (Kellner et al. 2000). Animal studies have shown that CCK-B receptor antagonists administered 30 minutes before either a conditioned fear stressor (CS) or an unconditioned fear stressor (UCS) inhibit the acquisition and expression of conditioned fear, and actually attenuate or prevent subsequent behavioural pathology (Tsutsumi et al. 2001; Adamec, Shallow, and Budgell 1997; Cohen, Kaplan, and Kotler 1999; Tsutsumi et al. 1999). When given 5 minutes after a UCS, however, no change in behaviour is observed (Tsutsumi et al. 1999). Although studies are underway, there is no human version of these compounds on the market.

The empirical approach in practice — Current treatment guidelines

Treatment Guidelines have been published on PTSD, e.g. Expert Consensus Guidelines (1999), APA Practice Guidelines (2004), NICE Guideline (2005). The evidence base for drug treatments in PTSD is considered to be very limited, but all guidelines recommend that, if drug treatment is to be used, then one of the antidepressants should be the first-line drug treatment.

Interestingly, the NICE Guideline specifically recommends paroxetine or mirtazapine for general use, and amitryptyline or phenelzine for initiation only by mental health specialists. The evidence base for this specific recommendation was derived from Bisson's meta-analysis (2007) of the relative effect size of therapeutic effect of various individual drugs in the treatment of chronic PTSD.

The empirical approach for children and adolescents

Kaplan (2002) stated that "very few studies have documented the effectiveness of pharmacotherapy for children and adolescents with PTSD". Guzofski (2006) stated that "randomized clinical trials are not available in children with PTSD". It can thus be seen that the evidence base for the pharmacotherapy of PTSD in children and adolescents is extremely limited.

Despite this, both authors recommended that the use of medication as adjunctive therapy for symptomatic relief may be necessary for children and adolescents suffering from PTSD, relying on the evidence base derived from adult studies. The issue of suicidality in pediatric patients treated with antidepressants is still not yet settled, because both increased and decreased suicidality has been reported. Caution is therefore required.

Rational Approach

The human stress response and the pathophysiology of PTSD

The human stress system has evolved for coping, adaptation, and preservation of the species. It encompasses central and peripheral nervous systems, the endocrine system, and the immunological system. Its two major components are the hypothalamic-pituitary-adrenocortical (HPA) system and the locus coeruleus/norepinephrine-sympathetic (LC/NE) system. Corticotropin-releasing factors (CRF) are the ignition switch for the human stress response, which not only activate HPA, LC/NE, and immunological mechanisms, but a complex cascade of reactions mediated by many other neurotransmitter, neurohormonal, immunological and metabolic mechanisms including adrenergic, serotonergic, opioid, glutamatergic, gabergic, cholinergic, and cytokine systems (Chrousos 1998; McEwen 1998). (It is important to keep in mind that CRF may also initiate more fine-grained actions involving only the HPA, only the LC/NE, or only other specific immunological or neurobiological systems. In the face of an overwhelming stressor, however, it is not unreasonable to consider CRF from the present standpoint, as the prime mover in the complex spectrum of actions that characterize the human stress response.)

PTSD results when a traumatic experience overwhelms the capacity of an individual's stress system. Failure to cope with the demands of traumatic stress might take a number of forms such as inability to mobilize an adequate response, inability to achieve normal recovery, and inability to calibrate the magnitude of the stress response to the actual psychobiological demands of the traumatic situation.

In short, PTSD exemplifies the human stress response gone wrong. As a result of the organism's failure to cope and recover, key psychobiological functions are altered. Dysregulation of HPA, LC/NE, and immune mechanisms produces many secondary abnormalities that are mediated through a cascade of downstream mechanisms. In chronic PTSD, a new balance is achieved in the face of such stable psychobioligcal alterations. Countermeasures are brought into play to compensate for: (1) the failure to mount an adequate response, (2) the failure to shut off activated mechanisms in order to achieve normal recovery, (3) the failure to habituate to repeated challenges of the same kind, and (4) the failure to calibrate subsequent stress system responses to realistic demands of the situation. There are also anatomic consequences of altered stress system function, including atrophy of brain regions such as the hippocampus. McEwen (1998) has called the process of achieving stability in the face of such altered neurobiological mechanisms, allostasis; the price of achieving such stability in the face of these deleterious functional alterations is called allostatic load. Allostatic load in chronic PTSD has already been detected in a number of key systems shown in Table 4.1 such as: HPA, LC/NE, opioid, and serotonergic systems. It is reasonable to expect that future research will detect allostatic load in glutamatergic, gabergic, and immunological mechanisms as well. More information on such abnormalities can be found elsewhere (Friedman 1999; Friedman, Charney, and Deutch 1995; Yehuda and McFarlane 1997) and in this article.

Allostatic load signifies adverse changes in neurobiological function. If there can be a change for the worse, however, then there might also be a change for the better. Indeed, allostasis in a positive direction would be expected to be salutogenic and buffer the potentially deleterious impact of allostatic load. We refer to such salutary changes as allostatic support (Friedman and McEwen 2002). Resilience against, prevention of, and treatment for PTSD can all be understood in terms of allostatic support.

Resilience and Prevention: General Principles

Individuals differ in their likelihood of developing PTSD following exposure to traumatic stress. Epidemiological research suggests that most traumatized people do not develop PTSD, even after surviving the most terrifying and dehumanizing interpersonal violence, such as rape, torture, and military combat (Kessler et al. 1995). There is growing evidence that a number of important risk factors affect resilience or vulnerability to PTSD, such as genetic endowment, childhood development, the history of abuse and/or neglect, education, trauma severity, and the posttraumatic recovery environment (Yehuda 1999). It has been suggested that psychophysiological factors such as reactivity, conditionability, resistance to extinction/habituation (Orr et al. 2000; Shalev 1995), and different personality configurations (Schnurr and Vielhauer 1999) also may constitute risk factors for PTSD.

From a psychobiological perspective, it seems reasonable to operationalize resilience and vulnerability in terms of the stress system's coping capacity. Resilient individuals are those who are abnormally equipped to: (1) mobilize CRF-activated HPA, LC/NE, immunological, and all other down-stream

Table 4.1 Treatment of PTSD

Neurobiological system	Proposed abnormality	Proposed treatment
Dendritic/neuronal degeneration	Hippocampal atrophy	Neurogenesis promoters: antidepressants, 5-HT_{1A} agonists, IGF-1 agonists
Limbic/cortical neuronal excitability	Sensitization/kindling	Anticonvulsants
Glutamatergic	Impaired glutamatergic synaptic function	Modulators of NMDA, non-NMDA, and metabotropic glutamate receptors
Substance P Opioid	Enhanced activation? Systemic dysregulation	Substance P antagonists Selective opioid agents or antagonists
Serotonergic	Systemic dysregulation	SSRIs, nefazadone, more selective 5-HT agents
Adrenergic	LC/NE hyperactivity Enhanced LC/NE activity at baseline Blunted NPY activity	NPY agonists, opioid agents, CRF antagonists, antiadrenergic agents (α_2 agonists, ß antagonists, α_1 antagonists)
HPA	GR supersensitivity Variable cortisol levels	Glucocorticoids (cortisol), DHEA, SSRIs
CRF	Increased CRF	CRF antagonists, NPY agonists, opioid agents

Note: PTSD = posttraumatic stress disorder; CRF = corticortopin-releasing factor; HPA = hypothalamic-pituitary-adrenocortical; GR = glucocorticoid receptor; LC/NE = locus coeruleus/norepinephrine-sympathetic; NPY = neuropeptide Y; DHEA = dehydroepiandrosterone; SSRIs = selective serotonin reuptake inhibitors; NMDA = N-methyl-D-aspartate; IGF-1 = insulin-like growth factor-1.

neurobiological mechanisms in the face of extreme or traumatic stress, and (2) shut off such activation when the stress response is no longer needed. Vulnerable individuals, on the other hand, are those whose stress response is inadequate or whose recovery is delayed after CRF activation of HPA, LC/NE, and other mechanisms (McEwen 1998; Dienstbier 1989; McEwen and Steller 1993).

Any intervention that bolsters resilience is prevention. Pharmacological strategies to prevent PTSD might be developed to fortify the stress system in people with functional deficits in a key component of their stress system, such as inadequate or excessive CRF mobilization.

Preventive pharmacotherapy for PTSD would begin with a psychobiological assessment protocol that would focus on the primary components of the stress response rather than downstream mechanisms. It might be a two-stage process measuring both baseline and elicited stress system measures. The first stage, analogous to a serum lipid profile for detecting individuals at greatest risk for atherosclerosis, might consist of baseline serum or urinary indicators of HPA, LC/NE, opioid, and immunological function. Abnormal levels of any of these stress system components might identify those individuals most vulnerable (or resilient) to developing PTSD following traumatization. Seeman, Singer, Rowe, Horwitz, and McEwen (1997) have used such a baseline battery to correctly identify individuals at greatest risk of exhibiting adverse health consequences from chronic stress (e.g., allostatic load).

Because the hallmark of PTSD is hyperreactivity, the second stage of stress system assessment might be a series of provocative tests to probe the coping capacity of the stress system itself. This would be analogous to a treadmill test to detect heart disease or a glucose tolerance test to detect diabetes mellitus in medical practice. Such provocative tests might include: (1) startle paradigms to assess physiological reactivity, conditionability, and resistance to extinction, (2) in vivo stress paradigms to assess mobilization of HPA, LC/NE, opioid, and immunological components of the stress response, (3) dexamethasone suppression test to assess glucocorticoid receptor sensitivity, (4) yohimbine provocation to assess LC/NE function, or (5) provocation to assess humoral or cell-mediated immunity. Should abnormalities be detected either at baseline or following provocation, the next question would be whether they can be corrected with pharmacological and/or behavioural treatment. Some possible medication treatment options include: CRF antagonists, dehydroepiandrosterone (DHEA), antiadrenergic agents, neuropeptide Y (NPY) enhancers, opioid modulators, and agents normalizing immunological responses.

Thus, I have outlined a prophylactic strategy to promote resilience and prevent PTSD that uses psychobiological tools to detect vulnerable individuals and that uses pharmacological (and behavioural) interventions to correct such deficiencies.

Recent research with US Special Forces military personnel provides a concrete example of this approach. Morgan led two studies (Morgan, Wang, Southwick, et al. 2000; Morgan, Wang, Rasmusson, et al. 2001) that monitored the stress response among military personnel exposed to an extremely stressful training experience at Fort Bragg, NC. They showed that individuals who were best able to mobilize NPY tolerated the experience and performed better than those unable to achieve comparable NPY levels. These results suggest that stress-induced NPY mobilization may be an important index of resilience against PTSD. It also suggests that pretreatment with an NPY agonist might be an effective prophylactic strategy to prevent PTSD among people in dangerous professions who are unable to mobilize sufficient endogenous NPY levels on their own.

Resilience and prevention for previously traumatized individuals

The previous discussion focused on a preventive strategy for people who have never been exposed to traumatic stress. What should be done for people who have had or probably will have such exposure? It was shown (prior to 11 September 2001) that in the United States, a nation that had not seen a war on its own soil since 1865, over half of all adult American men and women had been exposed to at least one traumatic event during the course of their lives (Kessler et al. 1995). In nations in which conflicts have or continue to rage within recent memory, the lifetime prevalence of exposure to traumatic events among adults is much higher: 91.9% in Algeria, 78.0% in Ethiopia, and 74.4% in Cambodia (De Jong et al. 2001). It is also known that there are a number of professions in which individuals are routinely exposed to potentially traumatic events in the course of their normal duties; these include soldiers, police, fire-fighters, emergency medical personnel, and disaster/refugee mental health clinicians. Thus, we must periodically repeat the baseline assessments and provocative tests for people who have been exposed to traumatic stress and for those in high-risk professions because they are at greater risk to develop PTSD.

A recent experiment suggests that trauma exposure itself may produce psychobiological abnormalities even among people who do not develop PTSD. Heim, Newport, Bonsall, Miller, and Nemeroff (2001) tested the adrenocorticotropic hormone (ACTH) response to CRF among three groups of women: those with a history of childhood sexual abuse (CSA) and depression, those with CSA and no depression, and a control group with neither CSA nor depression. The CSA/depressed group (all but one of whom also had PTSD) showed a blunted ACTH response in comparison to controls. In contrast, the CSA/no-depression (and mostly no-PTSD) group exhibited a significantly greater ACTH response to CRF than the controls. In other words, the traumatic stress of CSA produced opposite HPA abnormalities depending on whether the women had depression or not. The implications for PTSD prevention are that: (1) it may be especially important to foster resilience and bolster allostatic support for trauma exposed/non-PTSD individuals, and (2) the specific prophylactic pharmacotherapy required for such individuals may be different from what is needed for never-traumatized individuals.

Treatment of acute stress responses: Is there a morning after pill?

During the normal human stress response, CRF rapidly mobilizes HPA and LC/NE mechanisms. After the traumatized individual's requirements for such activation have passed, recovery of normal function is mediated, in part, through glucocorticoids, NPY, and opioids. It is possible that individuals most likely to develop

PTSD are: (1) those who produce the most intense HPA and/or LC/NE activation, (2) those who are unable to achieve normal recovery because of blunted glucocorticoid, NPY and/or opioid mobilization, or (3) a combination of both factors.

Most of these speculations are extrapolations from findings with chronic PTSD (Table 4.1) showing enhanced HPA function (indicated by elevated CRF and increased glucocorticoid receptor sensitivity) as well as enhanced LC/NE function (indicated by adrenergic hyperreactivity, yohimbine sensitivity, elevated 24-hour urine catecholamine, and downregulation of adrenergic receptors). Evidence for inadequate countermeasures to shut off the stress response is less robust but includes reduced glucocorticoid levels (Yehuda 1999), blunted NPY levels (Morgan et al. 2000; Rasmusson et al. 2000), and reduced opioid levels (Baker et al. 1997) among individuals with PTSD.

The few studies on acutely traumatized individuals are generally consistent with these findings. Emergency room patients with enhanced posttraumatic heart rates were more likely to develop PTSD than those with lower cardiovascular activation (Bryant, Harvey, Guthrie, and Moulds 2000; Shalev et al. 1998). Furthermore, emergency room patients with lower cortisol levels were also most likely to develop PTSD (McFarlane, Atchison, and Yehuda 1997; Resnick et al. 1995).

Therefore, future pharmacological treatment for acutely traumatized individuals will seek to reduce the magnitude of the stress response and to promote rapid recovery of normal function. As shown in Table 4.1, this might be accomplished by: (1) reducing CRF activity with CRF-antagonists, NPY agonists, or opioid agents, (2) reducing HPA activation with glucocorticoids (such as cortisol) or with an adrenal steroid such as DHEA, or (3) reducing LC/NE activation with NPY agonists and/or a variety of antiadrenergic agents (such as clonidine/guanfacine, propranolol, or prazosin).

Rapid antagonism of CRF would seem to be the most direct approach because it would reduce enhanced HPA, LC/NE, immunological, and secondary stress responses. Rapid reduction of posttraumatic HPA activation with cortisol (or other glucocorticoids) might prevent subsequent sensitization of glucocorticoid receptors, thereby preventing the development of glucocorticoid receptor supersensitivity. Indeed, treatment of septic shock patients with intravenous doses of the glucocorticoid, hydrocortisone, reduced the incidence of PTSD in comparison with patients who did not receive such treatment (Schelling et al. 1999). Finally, rapid antagonism of LC/NE activity with NPY agonists or antiadrenergic agents might not only prevent elevations in heart rate shown to predict PTSD (Bryant et al. 2000; Shalev et al. 1998) but would also be expected to prevent adrenergically mediated encoding of traumatic memories (Cahill 1999).

As more psychobiological research is carried out with acutely traumatized individuals, other pharmacological strategies will undoubtedly become apparent.

In short, although the evidences for preventive pharmacotherapy are still piecemeal and rudimentary, it does appear that the search for a "morning-after pill" to prevent PTSD will likely produce some clinically useful results eventually.

Treatment of chronic PTSD

The best treatment for PTSD is to abolish trauma in the first place by preventing war, rape, child abuse, torture, industrial accidents, etc. The next best approach is to foster resilience and bolster allostatic support so that individuals have optimized their coping capacity prior to exposure to traumatic stress. The third best option is early detection and treatment of acutely traumatized individuals to prevent a prolonged stress response that may produce abnormalities in HPA, LC/NE, immunological, and downstream mechanisms. When all such measures have either failed or not been initiated soon enough, the clinical challenge becomes the treatment of chronic PTSD.

Whereas the emphasis in prevention and acute intervention focuses exclusively on primary components of the human stress response (e.g., CRF, HPA, LC/NE, and probably immunological mechanisms) the focus in chronic PTSD may include downstream mechanisms. It may be on secondary neurotransmitter (e.g., 5-HT, dopamine, gabergic, N-methyl-D-aspartate [NMDA], substance P), hormonal (e.g., thyroid, gonadotropic, growth hormone), metabolic (Metabolic Syndrome X) or even neuronal consequences (e.g., sensitization, degeneration/atrophy). Furthermore, it is possible that PTSD is an evolving process that progresses through a sequence of stages in which the most severe stages are the least responsive to treatment (Post et al. 1999; Post, Weiss, and Smith 1995). End-stage PTSD may be a state marked by extreme hyperreactivity, hypervigilance, stress intolerance, cognitive disruption, and hippocampal atrophy.

Treatment goals for chronic PTSD may be very different than for more acute stages in the process. As discussed previously, treatment for acute posttraumatic reactions seeks to normalize the primary components of the human stress response (e.g., CRF, HPA, and LC/NE function), thereby preventing the development of PTSD. Treatment for recent onset PTSD seeks to eliminate symptoms of the disorder itself in order to achieve complete remission of reexperiencing, avoidant/numbing, or hyperarousal symptoms. In contrast, treatment of chronic PTSD might focus on a late-stage abnormality rather than the DSM-IV symptoms of PTSD. For example, hippocampal atrophy caused by dendritic and neuronal degeneration might be considered the major priority for treatment where the goal is to arrest the neurodegenerative process and, hopefully, improve cognitive function. As with any other chronic medical or psychiatric disorder, when it is too late to strive for complete remission, clinical interventions must try to optimize functional capacity and to prevent further deterioration.

Table 4.1 combines empirical findings with educated guesses about the spectrum of psychobiological alterations associated with chronic PTSD. It also proposes treatments (some of which are yet to be developed) to ameliorate such abnormalities. The number of neurobiological systems exhibiting PTSD-related abnormalities attests to the cumulative allostatic load from so many pathophysiological changes and illustrates why PTSD is such a complex chronic disorder characterized by deterioration in physiological, emotional, cognitive, and behavioural function.

Increased CRF activity and HPA dysregulation

Although I have emphasized reduction of CRF activity and normalization of HPA function as a major priority in preventive and acute interventions, it is not at all clear how much benefit might be gained from such measures in chronic PTSD. Clinical trials with CRF antagonists will certainly be conducted as soon as the pharmaceutical industry has developed agents safe enough to administer to humans. PTSD symptoms that might respond to such treatment include anxiety, hyperarousal, depression, and stress intolerance (Friedman 2000). Yehuda (1999) has suggested that HPA dysregulation, especially with regard to glucocorticoid receptor supersensitivity may contribute significantly to hippocampal atrophy. Friedman and McEwen (2002) have suggested that sustained HPA dysregulation in chronic PTSD may be a major factor in the increased vulnerability to medical disorders that appears to be associated with PTSD. Clearly, normalization of HPA function will be an important focus for clinical trials in both acute and chronic PTSD. As suggested previously, there are a number of pharmacological agents, in addition to CRF antagonists, that might be effective in this regard such as NPY agonists, opioid agents, selective serotonin reuptake inhibitors (SSRIs), and adrenal sterioids such as DHEA.

LC/NE system

As with the HPA system, preventive or acute intervention with antiadrenergic agents or NPY agonists has been emphasized previously. Treatment with such agents would be expected to reduce hyperreactivity, hyperarousal, hypervigilance, and panic/anxiety. Because adrenergic agonists enhance encoding of traumatic memories (Cahill 1999), antiadrenergic agents might ameliorate reexperiencing symptoms such as intrusive recollections, traumatic nightmares, PTSD flashbacks, and psychological/physiological distress triggered by trauma-related stimuli. Finally, as yohimbine can elicit dissociative episodes, antiadrenergic agents and NPY agonists may be especially effective treatment for dissociation (Morgan et al. 2000; Rasmusson et al. 2000; Friedman 2000).

Serotonergic system

The serotonergic system has important reciprocal relationships with both the HPA and LC/NE systems. Excessive HPA activity associated with chronic PTSD produces downregulation of 5-HT_{1A} receptors and upregulation of 5-HT_2 receptors, resulting in abnormal neurotransmission in key limbic nuclei (McEwen 1995; Southwick et al. 1999). Clinical studies have shown that PTSD patients exhibit a number of abnormalities associated with low 5-HT such as impulsivity, rage, aggression, depression, panic, obsessional thoughts, and chemical dependency (Friedman 1995).

The first two drugs to receive US Federal Drug Administration approval as indicated treatments for PTSD are the SSRI antidepressants sertraline and paroxetine. Among their other actions, SSRIs produce amelioration in all three symptom clusters of PTSD. Other antidepressants that affect serotonergic function such as nefazadone and amitriptyline have also shown efficacy in PTSD. Given the complexity of the serotonergic system with its large number of distinctive receptor types, it can be expected that in the future, greater efficacy may be achieved with more selective serotonergic agents (such as postsynaptic 5-HT_{1A} agonists), especially in chronic PTSD.

Finally, post-synaptic 5-HT_{1A} receptors found in astrocytes and other glia appear to promote neurogenesis of limbic nuclei (Lopez, Chalmers, Little, and Watson 1998). This may be another important reason why serotonergic agents will continue to play an important role in the treatment of chronic PTSD. The merging importance of neurogenesis in pharmacotherapy for PTSD will be discussed subsequently.

Opioid systems

Stress-induced opioid activity produces inhibition of both HPA and LC/NE systems, thereby promoting recovery. This system is also dysregulated in PTSD, with a number of reports showing abnormal beta-endorphin and methionine enkephalin levels (McEwen 1998; Wolfe, Mosnaim, Puente, and Ignacio 1991) as well as lower pain thresholds among individuals with PTSD (Shalev, Peri, Canetti, and Schreiber 1996). Therapeutic trials with opioid agents have scarcely begun. There is particular interest in the possibility that an opioid antagonist, such as naltrexone, may have unique applicability as treatment for PTSD patients with comorbid alcohol or substance abuse/dependency (Volpicelli, Balaraman, Hahn, Wallace, and Bux 1999).

Substance P

Based on their neuroanatomic distribution, it appears likely that substance P neurons are activated during the human stress response and have reciprocal interactions with the LC/NE system. Safe substance P antagonists have been synthesized and, in one randomized trial, the substance P antagonist MK-869 was as effective an antidepressant as the SSRI, paroxetine (Kramer et al. 1998). Research with this class of medications certainly seems to offer possibilities for important clinical and conceptual advances in PTSD.

Glutamatergic systems

Glutamatergic mechanisms are key to neuronal activation and to cognitive functions such as perception, appraisal, conditioning, extinction, and memory. Fear conditioning, sensitization, and resistance to extinction, all of which are mediated at NMDA synapses, are altered in PTSD (Charney, Deutch, Krystal, Southwick, and Davis 1993). Information processing is disrupted with respect to learning and cognition. Memory function may be altered in the direction of excessive recall (e.g., intrusive recollections) or problems with retrieval (e.g., amnesia). Finally, dissociation, an abnormality that is beginning to be understood as a very important posttraumatic symptom, appears to represent a disruption of glutamatergic function (Chambers et al. 1999; Krystal et al. 1995). It appears likely that medication normalizing neurotransmission at NMDA, non-NMDA, and metabotropic glutamate receptors may produce benefits for individuals with chronic PTSD.

Limbic/cortical neuronal excitability

Post et al. (1999) and Post, Weiss, and Smith (1995) have proposed that progressive increases in neuronal excitability of key limbic nuclei may be an underlying mechanism for the evolution of intrusive recollections. In early stages, there is a lowering of excitatory thresholds to stimulation by trauma-related stimuli. As the process continues, however, such neurons may fire on their own (without being triggered by external trauma cues) and produce spontaneous intrusive recollections, traumatic nightmares, PTSD flashbacks, and arousal symptoms such as hyperarousal, irritability, startle, and hypervigilance. This model of neuronal sensitization/kindling suggests that anticonvulsants may have a unique role in treatment of chronic PTSD, especially when spontaneous neuroexcitability has evolved. Unfortunately, promising earlier open label trials with the anticonvulsants carbamazepine and valproate have not led to randomized trials either with these medications or with newer anticonvulsants such as lamotrigine and gabapentin.

Dendritic/neuronal degeneration

Structural brain imaging has suggested that hippocampal volume may be reduced in PTSD patients (Bremner 1999; Sapolsky 2000). This reduction in volume may be caused by stress-induced HPA potentiation of glutamatergic toxicity on hippocampal neurons which produces atrophy and death of stress-vulnerable CA3 pyramidal neurons (McEwen 1999; Sapolsky 1996). My major focus here is not shrinkage of hippocampal volume per se, which may or may not be substantiated by future research, but rather stress-induced atrophy of neurons and loss of dendritic sprouting, which is well established in animal research. Given these findings in animals, and given the possibility that extreme stress may also produce hippocampal damage in humans, it seems reasonable to consider how this might be addressed pharmacologically.

With this as the context, it is very exciting to consider recent findings suggesting that antidepressant medications can reverse the atrophy of hippocampal neurons and increase cell survival and function. A key to antidepressant-induced neurogenesis may involve activation of Brain Derived Neurotrophic Factor (BDNF) through enhanced adrenergic and serotonergic signal transduction (Duman, Malberg, Nakagawa, and D'Sa 2000; Duman, Malberg, and Thome 1999). It is possible that all clinically active classes of antidepressants (e.g., tricyclic antidepressants, monoamine oxidase inhibitors, SSRIs and others) produce upregulation of BDNF and, therefore, promote significant neurogenesis. As noted previously, one gateway to neurogenesis may be through post-synaptic 5-HT_{1A} receptors (Lopez et al. 1998).

In addition to BDNF-mediated neurogenesis, it is important to consider another growth-promoting peptide, insulin-like growth factor 1 (IGF-1), that has been shown to promote brain metabolism, neural transmission, and neural growth and differentiation (Aberg, Aberg, Hedbacker, Oscarsson, and Eriksson 2000; Pulford, Whalen, and Ishii 1999). Because IGF-1 is suppressed by enhanced HPA activity, it is possible that a PTSD-related deficiency of IGF-1 may also contribute to hippocampal neuronal atrophy or loss of dendrites. In short, the emerging clinical pharmacology of neurogenesis may have direct relevance to future treatment of chronic PTSD.

Perhaps a brief disclaimer or point of clarification is in order at this juncture. There remain many questions about PTSD-related abnormalities (such as the possibility of damage or atrophy of hippocampal neurons), and even more questions about the utility or potential effectiveness of treatments that promote neurogenesis to reverse such abnormalities. Therefore, it is certainly not suggested here that current scientific evidence provides a sufficient rationale for clinicians to prescribe such agents (to promote neurogenesis) in chronic PTSD. It is suggested, however, that the data are sufficiently compelling and potentially of such great theoretical and clinical importance that the time has come to conduct clinical trials addressing this possibility.

Predictors of Drug Response

It would be expected that premorbid psychiatric illness, comorbid drug or alcohol use, sex, age, premorbid trauma history, medical or neurologic illness (e.g. previous closed head injury) would all be important variables in terms of an individual's response to treatment. In addition, the kind and severity of the trauma (both objectively documented and as perceived by the individual), the severity of early symptoms, when the symptoms developed, the level of psychosocial disability associated with the symptoms, current substance abuse or depression, or a concurrent anxiety disorder would likewise stratify individuals treated with medication. These factors would also affect the individual's response to treatment and risk of chronicity.

Against this backdrop, there has been an attempt to identify predictors of response and nonresponse to the pharmacologic treatment of PTSD. Martenyi et al. (2002) studied fluoxetine in men and women 18 to 65 years of age, enrolling patients from study centers in Belgium, Bosnia, Croatia, Israel, South Africa, and Yugoslavia who had experienced combat-related trauma. Subjects had a diagnostic evaluation period of 1 to 2 weeks, after which they were enrolled in a 12-week, double-blinded, placebo-controlled study. The primary outcome measure was the Treatment Outcome PTSD Scale. Secondary outcome measures included the Clinical Assessment of PTSD Symptoms, the Clinical Global Improvement Severity and Improvement, and the Davidson Trauma Scale.

Fluoxetine showed significant overall improvement compared with placebo, as well as a reduction of symptoms of comorbid disorders (based on the Hamilton Anxiety Scale and the Montgomery-Asberg Depression Rating Scale). Subgroups based on age, sex, type of trauma, number of lifetime traumas experienced, and the presence of dissociative symptoms were compared. Greater benefit was observed in males under 45 years of age and those who had suffered more than one traumatic event. Effect sizes were also noted to be larger in the combat-related trauma group, and those with no dissociative symptoms at baseline. Perhaps because of a high placebo response rate, effect sizes were smaller in the non-combat-related subgroup, the single event traumatic subgroup, and the group with dissociative symptoms.

These findings suggest a high placebo response in some subgroups — especially those with dissociative symptoms — and found that younger individuals with more recent traumas may respond better than older, more chronically ill, combat veterans. This would help explain the apparent discrepancy seen in other studies that show an apparent lack of effect of fluoxetine in combat-related PTSD and better clinical outcomes in non-Veteran's Administration patients.

In summary, there are few studies that reliably identify predictors of response to pharmacotherapy. Consistent with other anxiety and mood disorders, symptom severity, duration of illness, other premorbid or comorbid psychiatric illnesses, and particularly chemical dependency, all contribute to treatment response or resistance. In addition, the severity of the trauma, the number of traumatic experiences, and a history of childhood trauma may be prognostic for PTSD that is more severe and difficult to treat. In addition to predictors of severity and chronicity, dissociative symptoms may predict a high nonspecific treatment effect.

Some data suggest that PTSD may progress over time, with avoidance and numbing becoming more prominent. These symptoms may require a different approach to treatment than those symptoms present early in the course, such as arousal and re-experiencing. This shift in symptoms may indicate a neurobiolgic alteration that produces a resistance to pharmacotherapy and other modalities of treatment and may also result in longer-term disability and symptom chronicity.

Conclusion

The primary goals of psychiatric interventions after a disaster include reducing psychobiological distress, reducing the effects of secondary stressors, and facilitating successful coping (defined as one's ability to continue task-oriented activity, regulate self-emotion, sustain a positive self-value, and maintain and enjoy interpersonal contacts (Pearlin and Schooler 1978). Given the paucity of evidence for or against pharmacological interventions in the immediate postdisaster setting, it would seem prudent to advise psychotherapy as a primary intervention, only to be followed by the conservative use of medications when relaxation and family, social, and professional supports have failed (Morgan et al. 2003; National Center for PTSD 2003). There is evidence, however, that some forms of psychotherapy, namely single-session critical incident stress debriefing (CISD), may not reduce psychological stressors or prevent PTSD and may be associated with an increased risk of developing PTSD following the traumatic event (Rose, Bisson, and Wessely 2003). Psychotherapy is not innocent and without its own adverse effects.

One also could argue, however, that the presence of identifiable risk factors could push one in the direction of medicating so as to prevent a pathological outcome from the disaster. There are various ways of looking at this idea, and some conclude that cognitive therapies ultimately may have the same effects on the brain as certain medications. For instance, cognitive therapies may strengthen the PFC, increasing its ability to inhibit the amygdala, and positive active coping strategies may reroute neural circuitry, transforming the freezing pathway into a pathway mediating movement (Sullivan and Gorman 2002).

There is no way to fully know which interventions to offer, but some things are clear. Although it remains prudent to attempt to determine if the symptoms are either normal reactions in the postdisaster phase — although one must evaluate for the presence of secondary stressors before one assumes that the patient is out of the first phase of the response — or secondary to a budding pathological process, often pure and simple symptomatic management is all that is called for, especially when one cannot address etiologic considerations. When a patient presents with intense psychiatric symptoms that are impairing his/her functioning (e.g. psychosis, mania, prolonged insomnia, suicidality, or exceedingly poor judgment) and threatening his/her well-being, one must not hesitate to provide relief in the form of medications. At present, we can refer to treatment guidelines (e.g. NICE guidelines) for guidance, although we must bear in mind that the current evidence base is still only limited.

In the future, it seems to me that we will be more likely to achieve clinical success if we place less emphasis on the testing of already established antidepressants, anxiolytics, and anticonvulsants. Instead, I propose that we adopt a more proactive clinical approach and focus primarily on medications that have better psychobiological specificity with respect to PTSD (Table 4.2).

Table 4.2 Summary of Potential Medications for PTSD

Agonists of	Antagonists of
Neuropeptide Y	Corticotropic releasing factor
Serotonin (e.g., 5HT-1A) [a]	Catecholamines (e.g., noradrenaline and dopamine) [a]
Opioid [a]	Substance P
N-methyl-D-aspartate/glutamine	Kindling (e.g., anticonvulsants) [a]
Brain Derived Neurotrophic Factor (e.g. antidepressants) [a]	Cholecystokinin
Insulin-like growth factor-1	
Gamma-aminobutyric acid (e.g. benzodiazepines) [a]	

Note: [a] Generally available drugs in current clinical practice.

Note

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5

Resilience, Growth, and Distress After a Traumatic Experience

Samuel M. Y. Ho

Introduction

Over the last decade, human beings had been threatened by a series of devastating catastrophes either caused naturally or factitiously, such as the 2004 Southeast Asian mega-earthquake and its accompanying tsunami and the 9/11 terrorist attack, respectively. Adversities as such are undoubtedly a traumatic experience limited not only to victims and their significant others, but also people around the world. In fact, negative life events are inevitable in our life journey as many of us would encounter highly challenging life crises such as accidents, chronic illness, and bereavement in our lifetime. Past studies reported that individuals have a lifetime prevalence rate of 39–69% of experiencing at least one traumatic event (Breslau, Davis et al. 1991; Norris 1992), and that 21% experienced at least one traumatic event in the past year (Norris 1992). Traumatic events are incidents involving an individual's perception of actual or threatened death or serious injury, with the reactions of fear, helplessness or horror after the trauma (APA 2000). Indisputably, exposure to severe traumatic events is likely to precipitate an individual to experience significant distress or even psychopathology, such as posttraumatic stress disorder, depression, and anxiety. Recent research, however, revealed that different people exhibit different adjustment outcomes in the aftermath of trauma. While some people may suffer chronic psychopathology, others can recover shortly after or may simply show a lack of negative reactions, and yet there is another group of people who even report beneficiary finding after a traumatic experience. The latter two posttrauma outcomes (i.e. a lack of negative reactions and beneficiary finding) are often referred to as *resilience* and *posttraumatic growth* (PTG), respectively.

In this book chapter, I will first introduce the concepts of resilience and posttraumatic growth, as well as their competing models proposed by different theorists. Then, I will highlight the fundamental differences between resilience and growth. A detailed discussion of our latest research with the application of these concepts to the Hong Kong population is included at the end of this chapter.

Resilience

Resilience, in the face of adversity, is generally conceptualized as an ability to resume normal or pre-adversity level of functioning. Some researchers (Garmezy 1991; Lazarus 1993; Masten and Reed 2002) defined *resilience* as a return to the pre-adversity functioning after a period of significant distress, as illustrated in the resilience trajectory in Figure 5.1 (Carver 1998). Bonanno (2004), however, defined *resilience* as the ability to maintain a stable equilibrium psychologically and physically despite extreme adversity with a lack of negative reactions (Bonanno, Wortman et al. 2002; Bonanno 2004; Bonanno 2005; Bonanno, Rennicke et al. 2005; Bonanno, Galea et al. 2006). The dip in level of functioning of the resilient trajectory illustrated in Figure 5.1 was termed *recovery* by Bonanno (2004). According to Bonanno and his colleagues (Bonanno 2004; Bonanno, Rennicke et al. 2005; Bonanno, Galea et al. 2006), *recovery* entails a temporary phrase that gives way to threshold or subthreshold psychopathology (i.e. PTSD symptoms or depression symptoms), but returns to normal functioning after a period of at least a few months (see Figure 5.2). In summary, while Bonanno and his colleagues perceive resilience as an immediate bounce-back to normal functioning or even a relative absence of distress, other researchers believe that resilience entails an experience of significant distress but a return to pre-adversity functioning regardless of time (Garmezy 1991; Lazarus 1993; Carver 1998; Masten and Reed 2002; Lepore and Revenson 2006).

Posttraumatic Growth

Although different theorists use different terms to describe the phenomena of posttraumatic growth (PTG) such as stress-related growth (Park, Cohen et al. 1996); thriving (O'Leary, Alday et al. 1998), adversial growth (Linley and Joseph 2004) and benefit findings (Helgeson, Reynolds et al. 2006), they share the same observation that people often report positive changes after an exposure to trauma. Posttraumatic growth is a trajectory which shows that the posttraumatic level of functioning surpasses one’s pre-trauma level with time (Carver 1998; Tedeschi, Park et al. 1998b; Tedeschi and Calhoun 2004), as shown in Figure 4.1. To date, there is a consensus among researchers that posttraumatic growth should refer to “a change in people that goes beyond an ability to resist and not be damaged by highly stressful circumstances; it involves a movement beyond pre-trauma levels of adaptation" (Tedeschi and Calhoun 2004 p. 4). Hence, "better than before" is an easy but useful criterion to distinguish between posttraumatic growth and resilience, as we will elaborate on this later in this chapter. According to the qualitative data derived, Tedeschi and Calhoun (1995) postulated that the concept of growth covers three general domains, suggesting that exposure to trauma or adversity impels changes in the perception of self, relationship with others and the philosophy of life, which further embraces five sub-domains: personal strength, new possibilities, relating to others, appreciations of life and spiritual change (Tedeschi and Calhoun 1996; Calhoun and Tedeschi 2006).

By definition, a certain level of perceived threat (or level of stressfulness) and/or existential struggle is necessary in order for PTG to develop (Tedeschi and Calhoun 2004; Calhoun and Tedeschi 2006). But why would an encounter of a traumatic event lead to positive change? It was proposed that highly stressful events shatter an individual's assumptive world, and the process of restructuring the assumptive world allows the conscious experience and awareness of PTG (Parkes 1971; Janoff-Bulman 1992). According to the Social-Cognitive Transition (SCT) model of adjustment (Brennan 2001), people have a complex mental representation of the world — an "assumptive world" — to help them to predict or react adaptively to prevailing circumstances. The "assumptive world" is shaped by the socio-cultural context and is continuously revised according to personal experiences. Psychologically shocking events will act as a catalyst to change the existing "assumptive world" that may lead to both positive and negative transitions.

One might expect that the occurrence of PTG plays an important role in reducing psychological distress and fostering psychological well-being. However, data from most of the studies which examine the relationship between PTG and adjustments revealed mixed and contradictory results. An inverse relationship between PTG and reported symptoms of PTSD has been found on some studies (McMillen, Smith et al. 1997; Frazier, Conlon et al. 2001), but null or low to moderate positive associations were found in others' studies (Park, Cohen et al. 1996; Schorr and Roemer 2002). Zoellner and Maercker (2006) suggested that the nature of the study designs, as whether it's longitudinal or cross-sectional, and the standardization of measurements used in the above-mentioned studies, as the possible explanation for the inconsistent results found. Recently, Lechner, Carver et al. (2006) proposed that the relationship of PTG and PTSD could be in the form of an inverted U-shape, i.e. people with very low or very high PTSD tended to report less posttraumatic growth. This relationship is worth investigating in the future.

Besides the symptoms of PTSD, association of PTG with depressive symptoms and other outcomes have also been examined empirically, mixed results were again found. On one hand, studies have found no significant relationship between posttraumatic growth and depressive symptoms (Aldwin, Levenson et al. 1994; Cordova, Cunningham et al. 2001). On the other hand, however, studies with larger sample size or longitudinal study design across different populations revealed significant negative associations between PTG and depressive symptoms (Aldwin, Sutton et al. 1996; Frazier, Conlon et al. 2001). Furthermore, a recent meta-analytic review on 87 published articles in relation to posttraumatic growth and health outcomes had generated a conclusion that posttraumatic growth is related less to depression and more to positive well-being (Helgeson, Reynolds et al. 2006).

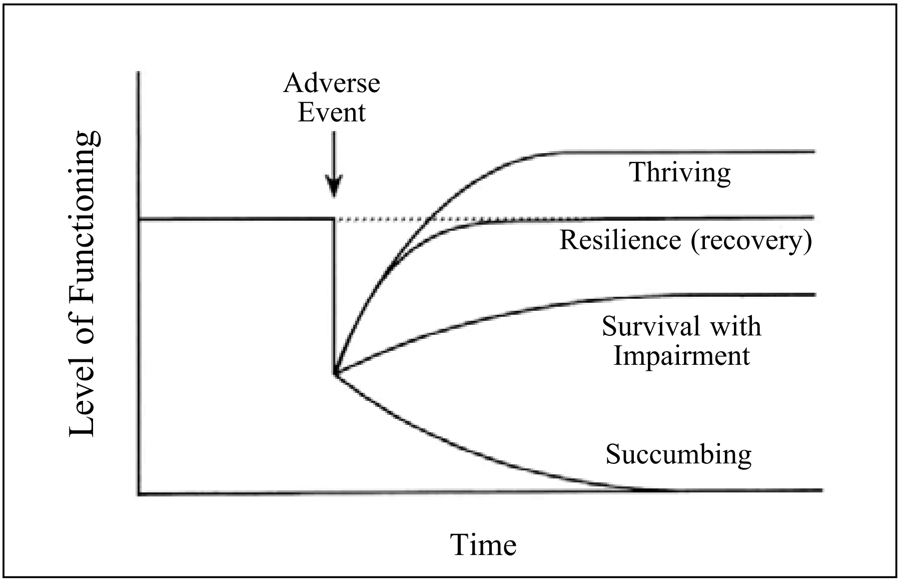

Figure 5.1 Response to adversity (Source: Carver 1998. Reprinted with permission from C.S. Carver.)

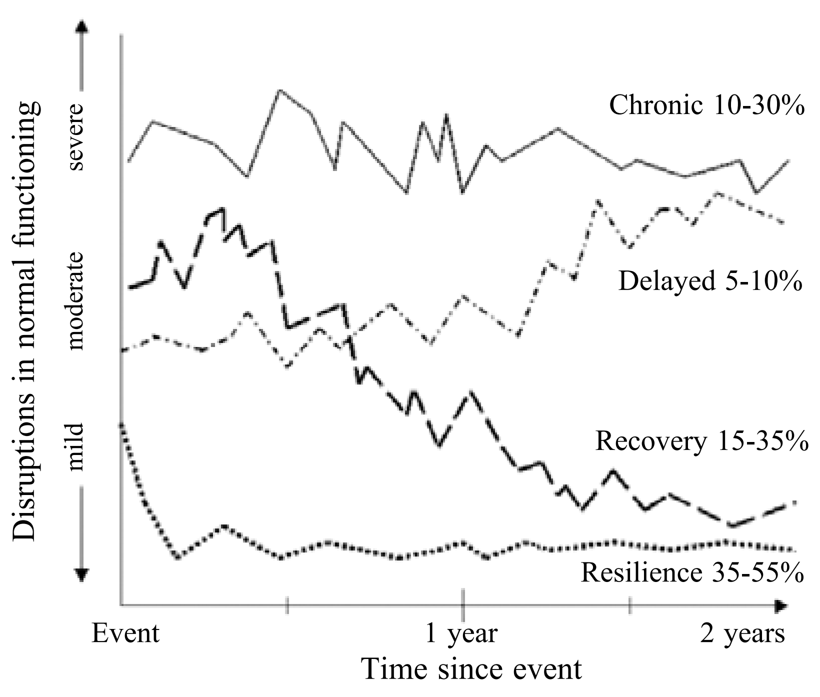

Figure 5.2 Prototypical trajectories of disruption in normal functioning during the two-year period following a loss or potential trauma (Source: Ho, Ho, Bonanno, Chu, & Chan 2010. Reprinted with permission from Ho, S.M.Y.)

Resilience Versus Posttraumatic Growth

Much discussion has been engendered about the differences between PTG and resilience. Ho (2007) explained two crucial differences between the concepts. First, while resilience refers to a return to pre-adversity equilibrium, PTG is the surpassing of pre-adversity functioning. More importantly, resilience may imply a plateau in the trajectory of functioning, yet PTG may suggest a process of continued growth. Tedeschi and Calhoun (2004) have argued that PTG is transformative, whereas resilience is not. Second, resilience is based on a quantitative measure according to prior condition (pre-adversity functioning), but PTG deals with qualitative changes that are not as easily measured. Such qualitative changes of PTG include individual development, positive reappraisal of life priorities, having a deeper sense of meaning, and a deeper sense of connection with others or with a spiritual force (Tedeschi and Calhoun 2004).

Investigators particularly interested in resilience have demurred that other researchers have mistakenly equated resilience with PTG, or that PTG is a level of functioning superior than resilience. Westphal and Bonanno (2007) have recently posited that "resilience outcomes provide little need or opportunity for posttraumatic growth" (p. 419), because resilient individuals simply are unlikely to struggle as much, and therefore less likely to attempt at meaning-making behaviors associated with PTG. Instead, it was proposed that people with the recovery trajectory are more likely to experience and report PTG (Bonanno 2005). The intriguing and on-going discussions about resilience and PTG continue to inspire new research and new conceptualizations.

Resilience and Posttraumatic Growth Research in the Chinese Population

Measuring posttraumatic growth

The Posttraumatic Growth Inventory (PTGI) is one of the most widely used paper-and-pencil measures of posttraumatic growth, developed by Tedeschi and Calhoun (1996). The PTGI contains 21 items measuring the degree to which an individual experienced personal growth following the struggle with adversity with a 0–5 response choice (0 = "I did not experience this change as a result of my crisis"; 3 = "I experienced this change to a moderate degree as a result of my crisis"; 5 = "I experienced this change to a very great degree as a result of my crisis"). The items in the PTGI were developed on the basis of a review of the literature and were administered to college students for establishment of psychometric properties. Principal component analysis with orthogonal rotation revealed five factors that accounted for about 60% of the variance: (a) Relating to Others; (b) New Possibilities; (c) Personal Strength; (d) Spiritual Change; and (e) Appreciation of Life. Both the full scale and the separate subscales of the PTGI have good internal reliability (.90 and .67–.85 respectively) and acceptable 2-month test-retest reliability (.71).

Ho and his colleagues have adopted a "modified etics approach" (Ho and Cheung 2007) to develop the Chinese version of the PTGI. Accordingly, they translated the original English version of the PTGI (Tedeschi and Calhoun 1996) into Chinese, followed by back translation to ensure linguistic equivalence (Ho, Chan et al. 2004). But instead of assuming the original English version of the PTGI can be applied to non-Western cultures without modification (as proposed by the etics approach), the researchers tested the psychometric properties of the Chinese version of the PTGI (CPTGI) among 188 Chinese cancer survivors in Hong Kong. The data were subjected to both confirmatory and exploratory factor analyses in order to test if the factor structure of the original PTGI can be generalized to Chinese population. The confirmatory analysis suggested that the original factor structure of the PTGI did not apply to Chinese cancer survivors. Consequently, the researchers conducted an exploratory factor analysis (EFA) with varimax rotation to identify the factor structure of the Chinese version of the PTGI. Fifteen items were retained based on criteria that their loadings on a factor exceed 0.5 without loading above 0.4 on other factors, and the difference between an item's loading on two factors larger than 0.3. Four factors that accounted for 59.93% of the total variance were identified. This figure is almost identical to that of the total variance accounted for by the five-factor model of the original PTGI (60%; Tedeschi and Calhoun 1996).

The five-factor model of the original PTGI includes the dimensions — Personal Strength, Relating to Others, New Possibility, Appreciation of Life, and Spiritual Change. The new four-factors model of the Chinese PTGI consists of the Self, Interpersonal, Life Orientation, and Spiritual. The Self (seven items, 25.11% of variance) factor, which is similar to the Personal Strength dimension, measures the change to self and includes willingness to express emotions, higher acceptance of how things work out in life, and developing new interests and opportunities. The Interpersonal (three items, 12.29% of variance) factor is similar to the Relating to Others factor in the original PTGI and measures the change in interpersonal relationships after cancer. The Life Orientation (two items, 11.25% of variance) factor measures people's change in life priority as well as belief about the changeability of things in life. The Spiritual (three items, 11.28% of variance) factor is similar to the Spiritual Change dimension of the original PTGI and measures change in religious beliefs and spiritual life after cancer.

The four factors derived from EFA were then subjected to two confirmatory factor analyses. The first-order CFA model fit moderately well. A second CFA was performed to generate a second-order factor model, which consists of an Intrapersonal Dimension (with Self, Spiritual, and Life-Orientation loading on the second factor) and an Interpersonal Dimension. The results showed that this model achieved a slightly better fit than that of the four factor first-order CFA model. This model is depicted in Figure 5.3.

Three factors of the Chinese PTGI namely, Self, Interpersonal and Spiritual, overlap with the three broad categories of posttraumatic growth proposed by Tedeschi, Calhoun, and their colleagues (Tedeschi and Calhoun 1996; Tedeschi, Park et al. 1998b). Similar dimensions have also been proposed by other independent studies in other populations such as bereaved people (Lehman, Davis et al. 1993; Epel, McEwen et al. 1998). This suggests some universality of these three dimensions of posttraumatic growth across cultures and populations. On the other hand, the Intrapersonal-Interpersonal second order factor model seems unique to Chinese and has not been reported elsewhere (Ho and Bai, 2010). Ho

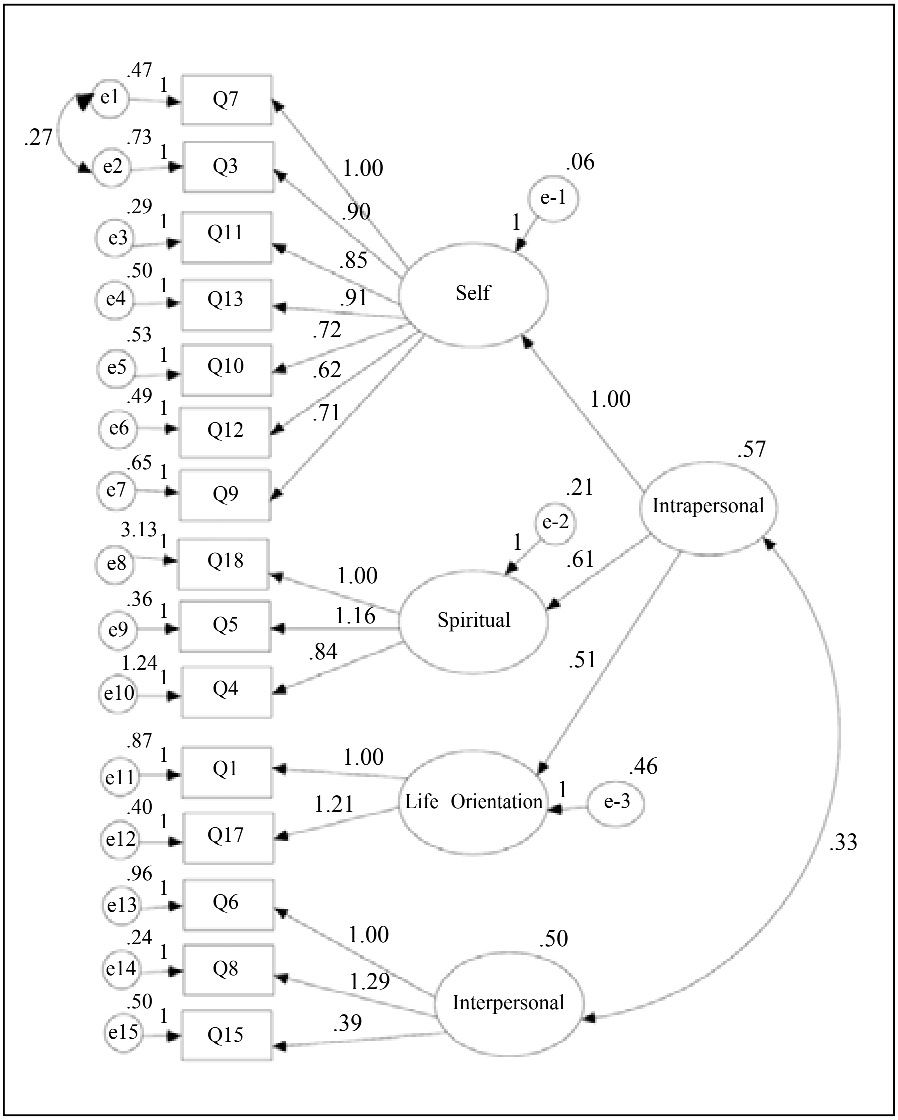

Figure 5.3 Factor Structure of the 15-item Chinese Posttraumatic Growth Inventory

Note: χ^2 (85, N=188) = 117.846, *p* = .011, GFI = .924, AGFI = .893, CFI = .961, TLI = .951 and RMSEA = .045. Please refer to Ho et al. (2004) for more information regarding this diagram. Reprinted with permission from Ho, S.M.Y.

and Cheung (2007) also found the interpersonal and intrapersonal subjective well-being dimensions among three independent Chinese samples. Such demarcation seems quite generalizable to other constructs of psychology, at least among the Chinese. It should be noted that researchers (Ho, Chan et al. 2004) could not identify an emotional dimension of posttraumatic growth from the various items (i.e. more relaxed, more aware of their own feelings, having greater compassion for other people's pain, etc.) among Chinese cancer survivors. It was speculated that Chinese tend to focus less on emotional experiences and therefore, were less able to appreciate positive emotional changes. Another possibility is that the emotional items of the original PTGI may not be appropriate to tap positive emotional changes among Chinese. Furthermore, it is not known if there are other dimensions of PTG relevant to Chinese that are not covered in Western literature. A qualitative study may help examine if there are other emics dimensions of posttraumatic growth among Chinese.

Resilience and Distress After the Severe Acute Respiratory Syndrome (SARS) Epidemic in Hong Kong

Catastrophic and novel infectious epidemics have occurred throughout human history, yet victims' mental health has only been better understood in recent years. The 2003 global pandemic from the severe acute respiratory syndrome (SARS) spread from Southern China to 32 counties over a period of a few months, infecting over 8,000 individuals and claiming approximately 800 lives in total (Ho 2003; Peiris, Lai et al. 2003; Wong and Hui 2003; Ho, Kwong-Law et al. 2005). The impact of SARS not only posed a great challenge to the local healthcare systems (Burkle 1996), but also causing a detrimental and pervasive impact on the mental health of victims, victims' families, health care workers (HCWs), as well as the society at large (Wing and Ho 2006).

During the SARS phase, it was found that a total of 386 staff and students working in hospitals and clinics were also infected, while 6 died (Ho et al. 2005). In a study by Ho et al. (2005), two groups were compared at 2 months after the epidemic tail — 97 infected but recovered HCWs, and 82 uninfected HCWs. Results showed that while non-infected HCWs were more fearful of being infected, infected HCWs were more concerned with other health problems and discrimination. Posttraumatic stress syndromes, such as intrusions (intrusive thoughts and images related to SARS), were positively correlated with fear of SARS among the infected HCW group. Studies reported that being an HCW during the SARS epidemic as an important predictor of later psychological distress, and that infected HCWs had more anxiety symptoms than uninfected HCWs (Cheung, Sheng et al. 2004; Cheung, Wong et al. 2004).

Recently, Bonanno et al. (2008) utilized a data sample of hospitalized survivors from the SARS epidemic (n = 997) to examine the long-term psychological impact that the disease had on survivors. Latent class analysis showed close resemblance to the four prototypical trajectories — resilience, recovery, chronic dysfunction, and delayed dysfunction — reported elsewhere (Bonanno 2004; Bonanno, Rennicke et al. 2005; Bonanno, Galea et al. 2006) (see Figure 5.2). A study by Bonanno et al. (2008) made an impact in several important ways. Firstly, while past research on longitudinal outcome trajectories were based on at-risk Western populations, this study was foremost in examining the prototypical outcomes in an Asian population. Secondly, with the exception of a recent study that examined trajectories of psychological outcome following treatment for breast cancer (Deshields, Tibbs et al. 2006), no one has yet studied the prevalence of different outcome trajectories following a health-related stressor event. And lastly, no study has yet examined the outcome patterns and predictors among a disease-exposed population in the immediate aftermath of an epidemic like SARS.

Explanatory Style as an Underlying Cognitive Mechanism of PTG

To date, several cognitive processing models have been proposed to account for posttraumatic growth that some individuals experience after a traumatic event including the revised model of posttraumatic growth by Tedeschi and Calhoun (2004), the organismic valuing process theory of growth by Joseph and Linley (2005), the stress model by Schaefer and Moos (2001), as well as the meaning reconstruction model by Neimeyer and his colleagues (Neimeyer 2000; Neimeyer 2001; Gillies and Neimeyer 2006). Recently, Ho and his colleagues have argued that one's explanatory style is an important factor affecting posttraumatic growth after an adverse event (Ho, Chu, and Yiu 2008).

Explanatory style is defined as the habitual tendency to offer similar sort of explanations to causes of bad or good events (Peterson, Buchanan et al. 1995). Three dimensions of explanatory style have been identified: internal ("It's me") versus external ("It's someone else"); stable ("It's long lasting") versus unstable ("It's only transient"); and global ("It affects many different aspects of my life") versus specific ("It affects only a particular aspect of my life"). A pessimistic explanatory style is a tendency to perceive bad events as internal, stable and global. This theory of explanatory style has been extensively researched and applied in clinical work (Hilt 2004). For example, there is strong empirical support for the prediction that people with a pessimistic explanatory style are more prone to suffering from depression, anxiety and posttraumatic stress symptoms in the aftermath of a disaster than people with other explanatory styles (Joseph, Yule et al. 1993; Mineka, Pury et al. 1995; Robins and Hayes 1995).

Ho and his colleagues proposed and further tested the rationale that explanatory style for good events will have more linkage with posttraumatic growth. A study of 105 college students in Hong Kong was conducted to examine the relationship between explanatory styles and benefit finding after bereavement (Ho, Chu, and Yiu 2008). The findings showed that the explanatory style of positive events, but not of negative events, was related to posttraumatic growth after bereavement. Individuals with a higher tendency to explain positive events as internal, stable and global also tend to have more self-reported positive changes after a traumatic experience than those who explain positive events as external, unstable and specific. The findings also imply that although an optimistic explanatory style for negative events may protect against suffering psychological symptoms in the aftermath of a trauma (Joseph, Yule et al. 1993; Mezulis, Abramson et al. 2004), it has little association with positive transformation.

Similar results were obtained in another study with 95 Chinese breast cancer survivors (Ho, Chan, Yau, and Yeung, 2010). This study intentionally included the element of psychopathology (PTSD symptoms), which was not explored in the study of Ho, Chu, and Yiu (2008). Findings showed that while explanatory style for positive events was associated with posttraumatic growth, it was not related to psychological distress. Specifically, optimistic explanatory style for positive events was more related to the intrapersonal domains of PTG. On the other hand, explanatory style for negative events was only related to psychopathology, and not to any dimensions of PTG. This was consistent with past findings of the positive relationships between pessimistic explanatory style for negative events and psychopathology (Joseph, Yule et al. 1993; Mineka, Pury et al. 1995; Robins and Hayes 1995). The results from both recent studies (Ho, Chu, and Yiu 2008; Ho, Chan, Yau, and Yeung, 2010) posit that explanatory styles of positive events and negative events may need to be considered as separate constructs when utilized to predict post-trauma adjustment. In addition, the negligible correlation found between PTG and psychopathology (Ho, Chan, Yau, and Yeung, 2010) may provide more evidence to existing research that PTG and psychopathology are constructs unrelated to one another.

The two studies above showed that an optimistic explanatory style for positive events may aid the process of adjustment after trauma and enhance posttraumatic growth. Ho and his colleges proposed that rather than focusing solely on how to change an individual's pessimistic explanatory style for negative events, clinicians should also pay equal attention to enhancing an optimistic explanatory style for positive events. It has been found that a higher self-esteem is related to more benefit findings (Carpenter, Brockopp et al. 1999; Schulz and Mohamed 2004), and we speculate that an optimistic explanatory style for positive events may facilitate to increase self-esteem. It is possible that one's explanatory style of positive events might influence one's post-trauma cognitive processing such as rumination (Tedeschi, Park et al. 1998a; Tedeschi, Park et al. 1998b) and meaning making (Neimeyer 2000; Neimeyer 2001; Gillies and Neimeyer 2006). For instance, rumination might mediate the relationship between explanatory style for positive events and posttraumatic growth, i.e. individuals with an optimistic style for positive events might tend to construct a more positive meaning for the traumatic experience as well as have more positive ruminations about the event which in turn might lead to more self-reported positive changes. These are possibilities that should be examined in future studies.

Conclusion

In this chapter, we have described the concepts of resilience and PTG in psychological literature. It should be noted that both concepts are indeed consistent with Chinese philosophies (Ho, Chu, and Yiu 2008). This may explain why PTG research has been growing rapidly in Chinese societies in recent years. Research on resilience and PTG among Chinese in Hong Kong are then described. For obvious reasons, we focus only on studies conducted by us and as a result, studies included in this chapter are not a comprehensive account of all studies in this area. At the end of this chapter, we have attempted to describe our current attempt to investigate the underlying mechanisms of PTG. At the time of writing this chapter, we have been conducting several experimental studies in this area, and we hope that more researchers and practitioners would join us to explore the underlying cognitive mechanisms of PTG vigorously for model building and application.

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Part III

Interpersonal Trauma

If architects want to strengthen a decrepit arch, they increase the load that is laid upon it, for thereby the parts are joined more firmly together. So, if therapists wish to foster their patients' mental health, they should not be afraid to increase that load through a reorientation toward the meaning of one's life.
– Victor Frankl, 1905–1997

6

Prevention of Child Sexual Abuse:

A Public Health Approach

Frendi W. S. Li

Introduction

There is clear evidence of significant associations between Child Sexual Abuse (CSA) and a range of mental health problems (Andrews, Corry, Slade, Issakidis, and Swanston 2004). As a result, there has been a proliferation of CSA prevention programmes in the past two decades both in Western countries and locally in Hong Kong. This chapter provides a review of the existing CSA prevention programmes, followed by a discussion on the problems that hinder the evaluation, development and efficacy of CSA prevention. The dissociation between intervention practice and theoretical base, and the inadequacy of targeting children in the prevention efforts will also be critically discussed, followed by suggestions on the direction for future research and service development.

Scope of the Problem

Prevalence studies found rates of CSA ranging from below 10% to around 50% in the populations, depending on the definitions of CSA they used. Locally, the Social Welfare Department (SWD) of Hong Kong defines child abuse as "any act of commission or omission that endangers or impairs a child's physical/psychological health and development." Under this umbrella concept, child sexual abuse "is the involvement of a child in sexual activity which is unlawful, or, although not illegal, to which a child is unable to give informed consent. This includes direct or indirect sexual exploitation and abuse of a child …" (SWD 1999, pp. 1–2).

In the United States, approximately 12% of children were sexually abused each year (US Department of Health and Human Services 2000). In the UK, the prevalence rate of CSA found in a nationwide retrospective random sampling was around 19%, excluding what they called the "at risk" group of children aged 13 to

15 having "consensual sex" with persons 5 years or older in age (National Society for the Prevention of Cruelty to Children [NSPCC], 2000). In mainland China, a regional retrospective survey again found CSA prevalence rate to be around 19% (Sun, Dong, Yi and Sun, 2006).

In Hong Kong, in 2005, 234 children were newly registered in the Child Protection Register for CSA, which was 30.7% of all the new child maltreatment cases (SWD 2005). In 2005–2006, non-government organizations (NGOs) such as Against Child Abuse (ACA) handled 67 CSA cases (ACA 2005–2006), while End Child Sexual Abuse Foundation (ECSAF) handled 98 cases (ECSAF 2005–2006). It was difficult to know whether or how much the three groups of children overlapped. In a local retrospective study using college sample, overall prevalence of CSA was reported to be 6.2% (Tang, 2002), which was lower than most of the findings in similar studies. Nonetheless, in a survey by an NGO, 58% of their family service users reported having been sexually abused during childhood (Caritas Family Service 1996).

CSA can occur once or over a period of time before the abuse is disclosed and discontinued. The sequelae or consequences of CSA commonly reported in the literature included anxiety, depression, somatic complaints, poor self-esteem, sexualized behaviours, learning problems, self-destructive problems and other behavioural problems. Some of these problems were found to persist into or resurface in adulthood. Kendall-Tackett and colleagues (1993) as well as MacMillan and Munn (2001) have published comprehensive reviews of the common impacts of CSA.

Overview of CSA Prevention Programmes

The public health model for prevention considers three levels of prevention (Daro 1988). In the context of child abuse, Primary Prevention programmes are those designed to prevent the occurrence of abuse. They can be directed universally at the general public or specifically at the high-risk groups. It is hoped that such preventive efforts can intervene before the child is harmed. Secondary Prevention attempts to avoid the continued occurrence of the abuse. This includes early detection and intervention of abuse. Finally, Tertiary Prevention aims to help the abused victim or the family as a whole overcome any possible undesirable impact of the abuse, prevent re-victimization of the child, minimize long term harm, and hopefully stop the victim-turned-abuser cycle.

The published CSA prevention programmes often focus on primary and secondary prevention. They are quite similar in their target, setting and content, with a fair degree of variation in the modes of presentation.

Target

Unlike prevention of physical child abuse which almost exclusively targets parents, CSA prevention programmes often aim at educating children to avoid or prevent being abused. While most of these programmes target school-aged children, some have included pre-school children as well. In Hong Kong, ECSAF provided different CSA prevention classes to junior primary and senior primary school students which reached over 30,000 students in 2005–06. They have also designed a sex education programme for junior secondary school students which incorporated the concepts of CSA prevention. In the same reported year 17,592 students participated in this programme. A special programme for the mentally handicapped was also being designed (ECSAF 2005–2006). The Social Welfare Department as well as others NGOs have also published various educational kits in relation to CSA prevention (See Appendix H).

When adults (e.g., teachers or parents) are involved in the programmes, they are often expected to assume the role of facilitators or teachers in educating children. ACA and an NGO, Caritas, did a series of "training of trainers" (TOT) programmes during 1998–1999, hoping to equip frontline workers such as student counsellors, kindergarten and primary school teachers, social workers, and child care workers to conduct CSA prevention programmes in their own work settings (Tsun 2001).

Setting

Most CSA prevention programmes reported in Western studies are school-based, although there have been some attempts to try out home-based programmes (Wurtele, Gillispie, Currier, and Franklin 1992a). Programmes provided by ECSAF are also school-based. Practically speaking, school is the place that can provide a captive audience of large number of children. Moreover, in view of the findings that a significant portion of CSA perpetrators are family members or close relatives (e.g., ECSAF 2005–2006; SWD 2005; NSPCC 2000), such school-based programmes provide a safety net outside home, and do not rely on the family's initiatives to educate children about CSA.

Content

CSA prevention programmes mainly aim at preventing CSA from happening and promoting early disclosure. These programmes vary in lengths and forms of presentation, but the content covered is often quite similar. Included in most programmes are the concepts of body ownership, potentially abusive behaviours, and skills to avoid or escape from abusive situations. For instance, children are taught that they have the right to refuse access to their bodies and that they do not have to let anyone touch or look at their private parts except for health reasons (Wurtele, Currier, Gillispie, and Franklin 1991). It is also common to teach children the Touch Continuum and how to differentiate between good, bad and confusing touches (e.g., Hitchcock and Young 1986). In addition, children will be taught to say "no" to potential abusers, and to refuse the solicitation and leave the situation. There is usually a strong emphasis on the idea that children must not keep a secret and must tell someone right away if they are asked to do so.

Local training programmes adopt similar content. The programme by Caritas, for instance, is named "3 Steps to Safety", and teaches children to: (1) say "no"; (2) leave; and (3) tell.

Trainer/presenter

Both experts and teachers are found to be effective trainers (Hazzard, Kleemeier, and Webb 1990), while parents on their own are not, even when given explicit instruction to follow (Miltenberger et al. 1990). Parents may leave out important information, or impart incorrect/ misleading information. For instance, many parents tend to tell children that strangers are most likely the perpetrators of CSA, when in fact they are not. Parents also tend to omit topics such as the types of behaviours perpetrators used to lure children (e.g., tricks, bribes, threats) (Wurtele, Kvaternick, and Franklin 1992b). Elrod and Rubin (1993) found that parents scored an average of 41% correct on a sexual abuse knowledge measure. A study done in mainland China involving 652 parents found that over half of them did not realize that children were more often sexually abused by people known or familiar to them. Only about 30% knew that usually there were no obvious physical signs that CSA had occurred. Nearly half of the parents in the study worried that CSA prevention programmes might lead their children to "know too much about sex" (Chen, Dunne and Han 2007).

In light of these findings, the TOT programme previously mentioned has correctly identified more appropriate trainers for CSA prevention.

Mode of presentation

Various modes of presentation have been used in CSA prevention programmes. These include behavioural skills training (e.g., Wurtele 1990), films/videotape (e.g., Poche, Yoder, and Miltenberger 1988; Byers 1986), theatrical presentations (e.g., Johnson 1987; Yost and Shert, 1986), puppet shows (e.g., Borkin and Frank 1986), lecture/discussion (e.g., Fryer, Krazier, and Miyoshi 1987; Conte, Rosen, Saperstein, and Shermack 1985), and written materials (e.g., Miltenberger and Thiesse-Duffy 1988). Many programmes use more than one modes of presentation.

Not surprisingly, research has found that programmes that actively involve children's participation through modelling and rehearsal are more effective than those that rely on traditional classroom learning (Wurtele, Marrs, and Miller-Perrin 1987).

How Effective Are These Programmes?

An incident was documented (Pelcovitz et al. 1992) in which 22 children from 2 different schools aged 6 to 10 years old did not disclose the long term abuse by an auxiliary school employee, despite having been exposed to a school-based CSA prevention programme. When interviewed by the researchers, only 10 of the children remembered having seen the CSA prevention film when it was shown to them again, and most of them had forgotten the movie's content. Most children felt the film did not help them know how to respond to their own abuse.

Another study by Gibson and Leitenberg (2000) found that among a sample of over 800 female undergraduates, 8% of the respondents who reported having attended a CSA prevention programme also reported having been subsequently sexually abused, compared to 14% of respondents who did not ever attend a CSA prevention programme. The authors interpreted the different rates as an indication of the success of the CSA prevention efforts. While there is no information on any confounding variables that may have influenced the differential rates, one thing is crystal clear – among the 507 respondents who had attended a CSA prevention programme in the study, 42 of them were still subsequently sexually abused!

The effectiveness of CSA prevention programmes targeting children alone has always been a subject of scrutiny. In addition to the methodological difficulty of programme evaluation, the content and philosophy of the programmes are often problematic.

Age-inappropriate / Abstract concepts for children

CSA prevention programmes often rely on teaching children to avoid being abused. Concepts such as good, bad and confusing touches, risk estimation, and rights and responsibilities are the main components of such programmes. However, these concepts are very abstract and beyond the comprehension of young children. Moreover, the concepts themselves often lack operational definitions that can be clearly explained to children in a simple way. Conte et al. (1985) demonstrated that children as old as age 10 still had difficulties learning abstract prevention concepts. Jacobs, Hashima and Kenning (1995) argue the "reasoning about risk requires the ability to understand the probabilistic nature of the world and to think about rare, but consequential, events … even adults are not accurate when judging uncertainty …" (p. 1444). In their studies, after exposure to CSA prevention programmes, while children could correctly estimate the base rates of sexually abusive acts, their perception of risks in videotaped scenarios were quite low. Young children's perception of risks, in particular, was often wrong.

Similarly, when given a command "not to tell" by an adult authority versus a suggestion "to tell" in some brief presentation they have seen before, young children, because of their stage of moral development, will likely choose to follow the "real" authority figure according to factors such as strength and relationship (Damon 1988). Pelcovitz et al. (1992) found that children as old as 10 years of age still failed to disclose abuse according to what was taught in prevention programmes because they felt "overpowered" by the abuser who was an authority figure.

Are the programmes doing more good or harm?

Invoking violence

Asking children to say "no" is one of the key elements in CSA prevention. However, research found that saying "no" was only effective if the children were not alone or when they were first approached. Yelling "No" or threatening to tell may in some case encourage the abuser to use more desperate measures, including violence (Elliot, Browne, and Kilcoyne 1995).

Reducing sense of security and trust

An 8-year-old boy in the case reported by Pelcovitz et al. (1992) said the film did not help him because his abuser was not in the movie. It is clear that we may have over-estimated some children's ability to generalize from the film to their real-life situations. Does that mean it has to be spelled out explicitly that the abuser could be anyone, including their parents, teachers, child-minder, scout leader, pastor and relatives? It is highly controversial whether we should put the idea into young children's mind that these dear people could be dangerous and harmful to them. Why should we let children live in such fears, especially when the effectiveness of CSA prevention that aims exclusively at children cannot yet be proved?

Methodological problems in programme evaluation

Measurement reliability

In CSA programme evaluation, self reports are commonly used to assess changes and gains after the programmes. Investigators often develop their own questionnaires specifically for their programmes and according to what changes they aim to assess. Reliability and validity of these "one-off" questionnaires are unknown. It has been difficult to compare effectiveness across programmes and thus has slowed down the process of improving programme design. Fortunately, a few questionnaires have been more widely used and have started to build up reliability. For instance, the Personal Safety Questionnaire (PSQ) (Saslawsky and Wurtele 1986) and the "What I Know About Touching Scale" (Hazzard, et al. 1991) have been used in several programme evaluations and claimed to have demonstrated reliability (Carroll, Miltenberger, and O'Neill 1992).

Measurement validity

Most CSA prevention programmes have essentially 3 components: a knowledge component, a behaviour component, and a judgement component in discriminating between abusive and non-abusive situations. While it may be reasonable to use questionnaire to assess knowledge acquisition and retention, it is highly questionable whether the acquisition of behavioural skills can be validly measured by forced-choice self report. It is also unsure how judgement of risks reflected by such "detached" paper-and-pencil tests translate into real-life situations. Surely the definitions of "good and bad touches" would be quite different for somebody known to and trusted by the child than when they are applied to some imaginary figures on paper.

Some investigators have looked at other methods of assessing effectiveness of CSA prevention programmes. These mainly include role-playing and hypothetical vignettes for the assessment of prevention skills (e.g., Jacobs et al. 1995; Wurtele et al. 1992a, b). Most studies report satisfactory use of taught skills in the hypothetical situations (MacMillan et al. 1994). However, how realistic do these hypothetical situations have to be for children to be able to generalize to real life abusive situations? There is a serious ethical question — To what extent do we simulate real abuse in prevention programmes and their evaluation? There has been demonstrated success in "in vivo" programmes simulating abduction (Fryer et al. 1987). The children were trained to take specific, concrete steps in reaction to well defined signs of possible abduction. In the post-test assessment, 78% of the children refused to accompany a stranger in the in vivo simulated abduction. However, because of ethical reasons, many CSA situations cannot be realistically demonstrated in training or assessment. The use of anatomically correct dolls is one possible alternative, but using them would again be distancing the training or assessment from real-life situations. On the surface, non-contact CSA may seem to post fewer ethical problems in training and assessment. However, whether certain non-contact behaviours (e.g., watching a child undress) are abusive or not often depends on the abuser's intention. It is very difficult to tell a child, in the case of non-contact CSA, which behaviours are abusive and which are not.

Generalizability — The gap between knowledge and behaviour

A meta-analysis of 16 studies of the effectiveness of CSA prevention programmes found significant post intervention effect size (mean d = 0.7). The effect measures they used were (1) sexual abuse concepts and knowledge, and (2) self protection skills (Rispens, Aleman, and Goudena 1997). However, it is highly questionable whether the learned self protection skills could be effectively applied in real life situations. There may be plenty of other forces prohibiting the child from performing such learned behaviours (Finkelhor et al. 1986).

Finkelhor, Asdigian, and Dziuba-Leatherman (1995) did a representative sample survey of 2000 youths age 10 to 16. Those who reported having been exposed to a CSA prevention programme were better on a short test of CSA knowledge. They reported more use of self-protection strategies learned from the programmes in face of real life victimization or threat. They were also more ready to disclose. However, they did not have lower levels of "completed victimizations" compared to the no-exposure group, and they were not better able to limit the seriousness of the assaults.

In summary, knowledge gain seems to be a clear outcome of these prevention programmes, but there is no clear evidence that the self protection skills learnt can be applied effectively in real life situations to halt "abuse completion" or reduce the seriousness of abuse. There is even less evidence regarding the efficacy in training children's judgement of CSA risks in personal situations.

Theoretical Concern — Can Children Prevent Their Own Abuse?

It is interesting to note that while most physical child abuse and neglect prevention programmes target potential abusers, CSA prevention has chosen to target the victims. This assumption that children can and should be responsible for preventing CSA from happening is highly debatable, and has absolutely no theoretical basis. In fact it contrasts sharply with the CSA literature which points to the confusion, powerlessness and helplessness of the child victim (e.g., Finkelhor et al. 1986).

Kaufman and colleagues (1998) contrasted the modus operandi (MO) of different types of CSA offenders (adult vs. adolescent, intra-familial vs. extra-familial). Though they all used desensitization to gain compliance and trust, and coercion to maintain victim silence, the actual strategies they used were wide-ranging and significantly different depending on the age and nature of the relationship to the victim. CSA prevention programmes which only target children cannot possibly incorporate all these different luring strategies in their training without confusing and scaring the children.

Elliott et al. (1995) interviewed 95 CSA offenders and revealed interesting and useful information that shed light on CSA prevention:

- 32% of the offenders were parents of the victims. Other known adults and strangers both accounted for 34% respectively.
- Most of them have a clear preference for the gender and characteristics of their victims.
- 42% felt that the victims being pretty was one of the important selection criteria.
- The child being young and small, innocent and trusting, etc. were also reported to be attractive characteristics, in addition to the way they dressed.
- 49% of the offenders reported being attracted to children who seemed to lack confidence or had low self-esteem.
- They would use a wide range of strategies to approach the children, including play or teaching activities, baby-sitting, affection and understanding, story-telling, or even befriending the whole family.
- 33% of the offenders specifically told the victims not to tell; 24% used threats of dire consequences, another 24% used anger and the threat of physical force; and 20% threatened loss of love or said that the children was to blame.
- Distressingly, only 26% said they would stop the abuse if the child was fearful, sad, distressed or cried. The rest were prepared to use threats, violence and coercion to control the child.

To what extent can these preferences, preparation and determination on the part of the abusers be effectively "prevented" by children? Even if a child is able to say "no", most of the abusers are prepared to use threats, coercion or physical force to get what they want. The fact that most of the abusers are known to the children further complicates the interaction process and makes it extremely difficult for young children to imagine that these trusted adults are doing something "wrong".

Findings like these make the average CSA prevention programmes look extremely naive and simplistic, as if the child could control the abuser by saying "no". The whole assumption that empowering children can effectively prevent or stop CSA is a distortion from traditional conceptualization which equates empowerment with choice, responsibility and competence (e.g., Dunst and Trivette 1987). In the case of CSA, there is no real choice on the part of the child victims; they are told they should not be responsible for the abuse; and their competence in stopping the abuse is assumed without theoretical backup. If CSA prevention consists only of these programmes, it would be highly dissociated from the theoretical base.

Integrating theory and practice — The way forward

For CSA prevention to be effective, it has to (1) acknowledge and address the complex nature of the problem; (2) be based on sound theories and knowledge in the area, such as child development theories, aetiology, risk factors and process of CSA, as well as the psychopathology and MO of child sexual abusers; (3) invoke systematic and coordinated efforts guided by a theoretical framework that target all risk levels.

Theory

Finkelhor has long ago suggested *four preconditions* before CSA could happen (1984). First of all the abuser has to have a strong motivation to engage in sexual activities with a child, then he or she has to overcome internal and external inhibitions (second precondition), and then overcome "external impediments" (third precondition), before he or she can get to a child. The child's resistance is only the last one of the four preconditions. A comprehensive CSA prevention programme should address all the four preconditions instead of focusing on children's reaction alone.

Practice

The public health model represents a systematic approach to addressing matters of broad public concern and great complexity. It often implies a comprehensive approach involving multi-disciplinary collaboration, and interventions that address knowledge, attitudes, behaviours as well as social norms. Examples include public health campaigns for the prevention of transmission of the HIV virus, drink driving, or drug abuse. Redefining problems as public health concerns has had significant implications for these areas in terms of public policy, funding, and intervention approach. It also shifts the focus from after-the-fact treatment to prevention.

Under the public health model, to identify effective approaches to prevention, Mercy and Hammond (1999) proposed four components: (1) public health surveillance; (2) risk factor research; (3) programme development and evaluation; and (4) programme implementation.

The first CSA prevention programme that used a public health model was the "STOP IT NOW!" programme in Vermont (Chasan-Taber and Tabachnick 1999). They targeted adults instead of children, and aimed to (1) increase awareness and knowledge about CSA in the community, and (2) encourage adult or adolescent abusers to self-report their abuse. The team did their own focused group research with the adults (abusers, friends and families of abusers and parents of victims) to identify important aspects for intervention. They also did a pre-programme assessment of CSA knowledge in a representative sample of the community. A broad-based media campaign was designed to increase the overall awareness and knowledge of Vermont residents about CSA. Specific messages were delivered to 3 groups of targeted audiences: adult abusers, people who know adults with possible sexual behaviour problems, and parents of sexually abusing youth. Collaborations were arranged between different agencies, such as child protection staff, treatment providers, parent groups, attorneys, doctors and medical institutions. A toll-free helpline would provide information to the caller, encourage self-report of abusive behaviours, and make referral for treatment. A protocol was set up so that abusers and potential abusers could receive confidential help without the fear of being reported to the authorities.

STOP IT NOW! represented an initial attempt to put the public health model in action in CSA prevention. Post-programme evaluation was difficult for the confidential part of the intervention, but otherwise yielded some promising results (Tabachnick and Dawson 2000). Nevertheless, the programme did not address all the preconditions in Finkelhor's model.

The way forward

With a view to integrating Finkelhor's model and the public health approach, Table 6.1 summarizes some suggestions by the author at different levels of intervention.

Table 6.1 A Public Health Model of CSA prevention that encompasses measures to tackle all 4 preconditions in Finkelhor's model

<table>
<tr><th></th><th>1st Precondition:
Abuser's motivation to engage in sexual activities with children</th><th>2nd Precondition:
Abuser's internal and external inhibition</th><th>3rd Precondition:
External impediments</th><th>4th Precondition:
Child's resistance</th></tr>
<tr><td rowspan="2">Primary Prevention</td><td rowspan="2">Social campaign on children's rights and to bring out / reinforce positive elements (e.g., duties to protect and care) in patriarchal culture
School curriculum on healthy development of sexuality and gender roles.
Treatment for high-risk groups (e.g., youths with emotional deficits compatible with sexual abusers and potential abusers struggling with deviant sexual responses)
Family wellness programmes with specific components on CSA-related risk factors
Home visitation and help for at-risk families</td><td>Education programmes targeting CSA-related cognitive distortions
Public appeal to promote zero tolerance of CSA</td><td>Strong message to the public that it is adults' responsibility to protect children
Training for parents and child workers
Screening of child workers
Increase safer child minding services</td><td rowspan="2">Positive elements in routine child education (e.g., self esteem, assertiveness, age-appropriate sex education)</td></tr>
<tr><td colspan="2">Public education programmes based on empirical facts of CSA, to eradicate myths and the blame on victims</td></tr>
<tr><td>Secondary Prevention</td><td>Voluntary treatment for unexposed abusers</td><td>Legal system and procedures that are more protective of children and deterring to potential abusers</td><td>Support for adults supervising at-risk youths</td><td>CSA prevention programmes for children (plus efforts to make them feel safe enough to disclose)</td></tr>
<tr><td>Tertiary Prevention</td><td colspan="2">Offender treatment and post-release follow-up</td><td></td><td>Victim treatment</td></tr>
<tr><td rowspan="2">Research</td><td>Aetiology of adult sexual interest in children; treatment of deviant interests and sexual responses; risk factors of CSA and ways to reduce them; role of cultural norms</td><td colspan="2">Epidemiological studies; basic facts about CSA (e.g., short-term and long-term impacts); pathways to becoming an abuser, offenders' MO; offenders' views on what would stop them; what legal procedures can effectively deter abusers</td><td>Role of positive elements in CSA prevention</td></tr>
<tr><td colspan="4">Programme evaluation</td></tr>
</table>

First precondition: Abuser's motivation to engage in sexual activity with children

Various hypotheses have been put forward as to why abusers find children sexually attractive. For instance, there is the notion that abusers are themselves emotionally immature, have a low self esteem and little efficacy in social relationships. Relating to children thus makes them feel more powerful, respected and in control (e.g., Loss and Glancy 1983). Feminist ideas, on the other hand, hold that sexual abuse grows out of certain themes in normal male socialization that justify sexual exploitation of children (e.g., Howells 1981). (Readers may refer to Finkelhor et al., 1986, for a review of various theories explaining abusers' sexual interest in children.) Research is desperately needed in this area, not only on understanding the aetiology of the adults' sexual interest in children, but on possible ways to reduce such interest or deviant pattern of arousal.

Offender treatment

In Hong Kong, the first residential treatment unit for sex offenders in Southeast Asia was established in 1998 — the Sex Offender Evaluation and Treatment Unit of the Correctional Services Department. They provide Core Treatment Programmes (CTP) for those assessed to be of high risk of re-offending, and self-help programme for those of moderate risk. The CTP consists of comprehensive and intensive group therapy that lasts for 6 months. The content includes awareness, mood management, modifying distorted sex attitudes, tackling deviant sexual interests, relapse prevention, and victim empathy training. Offenders have reported better understanding of their problems, increased awareness of high-risk situations, enhanced victim empathy, increased sense of responsibility in the offense, and better knowledge of relapse prevention skills. Most of the sex offenders would also undergo post-discharge supervision for a period of time.

This is a good example of how a government correctional department is actually involved in reducing the first precondition for CSA. Unfortunately, not only is it not clear how many of these sex offenders are child abusers, the efficacy of these treatment programmes is also unknown due to the lack of published data. In addition, the treatment is not compulsory. The very "hard-core" sex offenders may not see the need to seek treatment. Since some uncontrolled studies in the West did find lower recidivism rates after the introduction of similar treatment programmes (Hanson and Bussiere 1998), the Government could consider using incentives (such as activity privileges or shorter prison stay) to encourage more offenders to join these treatment programmes. Research data on efficacy should also be collected for further development of these programmes.

Treatment for unexposed abusers

There are a sizable portion of CSA abusers and potential abuser who are never reported or incarcerated. It would help to curb the first precondition if similar treatment programmes are made available to people in the community who are struggling with their deviant sexual arousal towards children. This requires coordinated efforts between government departments and community organizations.

Treatment/training for at-risk youths

Research has also found some common characteristics among sexual abusers, including the inability to articulate needs and emotions, to read and interpret emotional cues in others, and a distorted attribution of responsibility (Landry and Peters 1992). Many child abusers begin their abusive behaviours in adolescence (Shaw, Lewis, Loeb, Rosado, and Rodriguez 2000). If at-risk youths can be identified early in school or college, appropriate counselling or training (e.g., empathy training) can be provided. At the same time, school curriculum should include fostering prosocial behaviours as well as healthy development of sexuality and gender roles in adolescents.

Family wellness

On a more general level, maladaptive schemas or "implicit theories" formed in childhood are thought to predispose some individuals to CSA-related cognitive distortions and subsequent abusive behaviours (Ward 2000), whereas programmes promoting family wellness and some home visitation programmes have been shown to reduce child maltreatment (MacLeod and Nelson 2000). Research should be carried out, along with that on the risk factors of CSA, to see if similar programmes have any preventive values for CSA. Special attention should be paid to families at higher risk for CSA, such as step-families, single parents, and children looked after by non-parents. In Hong Kong, many different government departments and NGO's offer programmes to enhance family well-being. Some of these use a health perspective (e.g., the Family Health Service of the Department of Health), and others use a more psychosocial perspective (e.g., the family programmes run by Integrated Family Services Centres). However, there is no evidence that these programmes have specific components on reducing CSA-related risk factors. It will take a central organizing body to coordinate the works of different service providers in order to achieve consistent and pervasive CSA prevention.

Cultural awareness

On a societal level, we need to think about how to promote correct attitudes towards family and children. The feminists suggest that patriarchy is the most important contributor to sexual abuse. Ward's idea of "entitlement" (i.e., "I'm the king of my castle, and it's my right to do what I please") has received some preliminary research support (Marziano, Ward, Beech, and Pattison 2006). Systematic study is still lacking regarding how a sense of male entitlement to sex or ownership of women and children contributes to the risk to commit CSA. Research is needed in filling this knowledge gap. Since the Chinese culture is known to be quite patriarchic, CSA prevention efforts should pay special attention to this aspect. Apart from entitlement, the duties to protect and care are also embedded in patriarchy. Efforts should be spent on bringing out the positive elements of our ingrained patriarchal culture.

Second precondition: offender's (lack of) internal and external inhibition

Internal inhibition

Many studies have shown that cognitive distortions may be important in letting the abusers overcome their internal inhibition (e.g., Hanson, Gizzarelli, and Scott 1994; Hayashino, Wurtele, and Klebe 1995). For instance, Stermac and Segal (1989) found that child molesters perceived more benefits to the child as a result of the sexual contact. Howitt (1995) suggests that such cognitive distortions provide the abuser with an interpretive framework that allows them to justify, rationalize, and essentially excuse their abusive behaviours to themselves. Ward and Keenan (1999) further elaborated the idea to include implicit theories (alternatively termed as core beliefs or schemas in the literature) of the abusers, which often fall into one of five areas: (1) child as a sexual being; (2) entitlement; (3) dangerous world (i.e., that the world is inherently hostile and dangerous, and people untrustworthy); (4) uncontrollable (i.e., emotions and behaviours are out of one's direct control); and (5) sexual activity is harmless. Under these beliefs and cognitions, an individual who has sexual desires towards children would not have much internal inhibition for initiating sexual contact with them.

Similar to what has been discussed and suggested in the beginning of this chapter, a lot more can be done at different levels and by different organizations to reduce CSA-related cognitive distortions. For instance, life education programmes designed by the Education Bureau that are routinely run at schools could help correct the above cognitive distortions before they take root in the youngsters' minds. Programmes for at-risk youths and families could also include this aspect. If there would be a treatment service for unexposed abusers, cognitive distortion is no doubt an important component of the treatment package. On a societal level, public education programmes and infomercials should also aim to correct these distorted attitudes. Recently there has been a TV infomercial on family violence, which says the parents have rights in deciding a lot of things in a child's life, but that should not include deciding to put the child to death. Similar mass education attempt could actually apply to CSA prevention.

External inhibition: a) Public attitude

It is not uncommon to see public appeals on TV condemning physical child abuse or spouse-battering, with women and children with horrendous bruises and wounds appearing on the screen, showing how the whole family would be badly damaged by such abuse. This type of advertisement not only appeals to the abusers' conscience but also raises public awareness and sentiments of condemnation which can serve as some kind of external inhibitory force. In comparison, most CSA prevention appeals are much more subtle. Possible serious damages to the victim and family are seldom mentioned explicitly.

There seems to be a strange ambivalence on a societal level towards blaming perpetrators of CSA, especially when they are parents of the victims. This is evidenced by the wide acceptance of the myth that most CSA perpetrators are either mentally ill or alcoholic, or have some family problems, and are therefore not fully responsible for the abuse (Hall and Lloyd 1993). In the 1980s, many people believed that because children did not report immediate, or had "allowed" the abuse to go on more than once, they had to be considered "participants" rather than victims (Krieger, Rosenfeld, Gordon, and Bennett 1980; Yates 1982). A study found that 35% of law enforcement officers and 69% of child protective service workers considered teenage CSA victims as guilty as the abusive father (Wilk and McCarthy 1986).

In the West, it is believed that the above attitudes were largely a legacy from the Freudian view of childhood sexuality, and had no support from modern empirical research findings in CSA (Bolen 2001). Research is needed to understand the reasons behind similar public ambivalence in the Chinese culture. In any case, the public needs to develop a consensus that no excuse is ever good enough for an adult to sexually abuse a child. To increase the abuser's external inhibition, large-scale community educational programmes based on up-to-date empirical findings should be conducted to eradicate historical myths and promote zero tolerance of CSA. To this end, various NGOs as well as SWD have conducted community educational programmes. However, no evaluation study could be identified as to the efficacy of these programmes. Moreover, according to the publicity materials, many of these programmes teach about guarding children from strangers (in addition to the traditional tactic of asking children to say “no” and to tell). They often neglect to mention the fact that many CSA happens in the family or in the hands of those persons known to or trusted by the child. Furthermore, many of these programmes seem to lack depth, and seldom disseminate important information such as the myths (cognitive distortions) held by abusers, multitude of locations and luring methods the abusers use, and devastating long-term sequelae of CSA. Incorporation of such specific knowledge in community education programme could enhance adults’ alertness of possible abusers lurking around their children. This idea would in turn serve as an external inhibition for the abusers.

External inhibition: b) Legal system

Traditional CSA prevention programmes ask children to tell about their abuse, but how much are they believed? Tang and Yan’s (2004) study in Hong Kong showed that one-third of the adults interviewed would be skeptical about children’s report of CSA. Research revealed that the majority of substantiated cases of sexual abuse are not prosecuted. Tjaden and Thoennes (1992) found that criminal charges were filed in only 17% of all cases of child sexual abuse. Further, of those cases sent to prosecutors, only a small percentage of offenders are actually sentenced. Martone, Jaudes, and Cavins (1996) also found that convictions occurred in only 15% of all cases of probable CSA. Cross, Whitcomb, and De Vos (1995) conclude from their study that child sexual abuse trials are rare, with cases being four times more likely to be declined than accepted by prosecutors.

In Hong Kong, in 2005, among the 234 new CSA cases on the Child Protection Register, not counting the less than a hundred NGO cases, only 108 cases were “investigated” by the police (Hong Kong SAR Government, 2005). No data were available on the actual number or proportion of conviction, or the nature or severity of sentence. Another local study found that among 123 college student survivors of CSA, 39% had told somebody of their abuse. Among these disclosures, 56% went without follow-up, 8% of the victims were told not to say it again, 8% were told off or teased, 3% received counseling, and 1 perpetrator was caught (Tang, 2002).

Prosecution and conviction statistics like these are indeed a mockery to the “to tell” advocacy in existing CSA prevention programmes, and certainly do not help reduce the abusers’ external inhibition. Careful consideration should be given to how the legal system could protect our children more effectively. One example is the mandatory reporting of child abuse. Mandatory reporting will give the potential abusers a clear message that society and the legal system are taking CSA seriously, and that it is every adult’s responsibility to protect the children. This may help increase the external inhibition of the potential abusers. Many Western countries have adopted this practice. The idea has also been actively considered locally, and hopefully will be in place in the near future.

Within the social and medical services settings, SWD has developed a very clear Procedural Guide for Handling Child Abuse Cases (most currently revised in 2007). In the investigation stage, the police and SWD will form a Child Protection Special Investigation Team (CPSIT) to handle allegation or suspicion of serious child abuse with a view to collecting evidence which will be admissible in criminal proceedings, but at the same time preventing further trauma to the child through having to repeat details of the allegation to different persons or in public. There would be trained personnel who would conduct the investigation in a non-threatening manner. Less serious cases would initially be handled by the case worker if it was an old case, or by the Family and Child Protective Services Units (FCPSUs) of SWD if it was a new case. The practice is very considerate for the child victim and the family involved. However, to the lay persons (e.g., the non-offending parent who might be worried about the impact of disclosure), it may not be clear what will happen if they decide to disclose CSA. To this end, the Government may consider compiling a set of information on the legal aspects of CSA, including the investigation and legal procedures, the laws that are involved, and the consequences of violating these laws. Such information could be made available on the internet, telephone helpline, TV infomercials or in the form of pamphlets. The wide availability of such information would again give a clear message to the potential abusers regarding the legal system's unyielding position on CSA.

Furthermore, local research on the abusers' MO and their own views on what could possibly stop them would also shed useful light on how to tackle this second precondition.

Third precondition: Lack of external impediments

The third precondition occurs under situations such as unavailability of supervising adults, their low awareness of the risk of CSA, and the various misconceptions and myths about CSA held by the adults. Parents and adults who come into frequent contacts with children (e.g., home-helpers, teachers, tutors, child-minding relatives and neighbours) are the "last hurdle" to the abusers before the latter could get to the children.

Knowledge

Unfortunately, studies showed that many parents and adults in the community did not have accurate knowledge about CSA. Education and training for parents and other child workers are in desperate need. Such training should include pertinent information on CSA that has strong theoretical and research bases (e.g., prevalence, impacts, high-risk situations and luring methods), thereby increasing adults' awareness and effectiveness in providing protection for children. The evaluation of the TOT programmes by ACA and Caritas showed that after the training, the participants rated some of the abusive situations as being more serious than before, and was more ready to report and follow-up in many of the case vignettes (Tsun 2001).

Attitude

A recent study in Hong Kong revealed that only 24% of the interviewed adults showed definite intention to participate in CSA prevention programmes (Tang and Yan 2004). This may have been due to the public's lack of awareness of their role in child protection, which is perpetuated by existing CSA prevention efforts that focus only on children. The public needs to receive a strong message that it is the adults' responsibility to identify risky situations and protect our children, and that CSA prevention efforts that rely exclusively on children to prevent their own abuse are bound to fail.

Early intervention

Researchers have also highlighted the role of caregivers' supervision and monitoring as a critical factor for inhibiting adolescents' antisocial and delinquent behaviour (e.g., Forehand, Miller, Dutra, and Chance 1997). Education and support should be provided to parents and teachers of youths with deviant sexual behaviours in order for them to identify the problems early, bring the youths to treatment, and help supervise and prevent the youths from acting out their problems.

Policy

On the community level, the Review of Sexual Offences Sub-committee of the Law Reform Commission released a consultation paper in 2008 containing interim proposals for a sex offender register. The matter is still under careful consideration. In principle, screening of people working with children would be a practical and important "external impediments" for the abusers.

Fourth precondition: The child's resistance

When it comes to the fourth precondition, the question is not whether to educate children about CSA but how to do it in an effective and sensitive manner. If we really want to include children in CSA prevention, positive elements should be incorporated in the programmes in addition to (if not instead of) the traditional content. Self-esteem, confidence and problem-solving skills are some examples. Research findings have shown that many CSA abusers tend to pick children who are lacking confidence, submissive and shy. Appearing confident and assertive may be a "turn-off" for the abuser, and hence a more effective "prevention" than "saying no". Moreover, the ability to say "no" is very much related to self-efficacy and a healthy esteem. More research is needed to ascertain the preventive values of including such positive training elements.

With regard to the "knowledge gains" in the programmes, studies have shown that differences between pre- and post-test scores fail to reach significance level in 6-month follow-ups (e.g., Tutty, 1992; Kolko, Moser, Litz, and Hughes 1987). Since children cannot assimilate and thus do not remember information that is irrelevant to or "beyond" them, the focus of these programmes should perhaps be shifted to helping children learn about their own sexuality according to their developmental stages. Acceptance of their own curiosity and possibly pleasant feelings from their body may serve as a foundation on which children assimilate and accommodate related information. Giving children the permission to talk and learn about sex in an age-appropriate manner helps them understand what is right, and consequently helps them to tell what is wrong. This approach may be able to avoid the pitfall of attaching negative connotations to sexuality in the young minds. It also removes the mystery and fear about their body reactions which could be taken advantage of by abusers.

We should also listen to and learn from the experience of those children who have been abused to make the prevention programmes realistic and practical. For example, among the children mentioned earlier who did not disclose the abuse, a 7-year-old boy said his parent would be angry with him if he told them. Two 10-year-old girls said they were too embarrassed to tell their parents. In the local study by Tang (2002), among those who disclosed their CSA, only 55% told their parents, 8% told social workers, and 3% told teachers. The victims' reactions point to the fact that apart from encouraging children to disclose, we must make them feel safe enough to talk to us in the first place. However, none of the existing prevention programme found in the literature mentioned parent-child or teacher-pupil relationship in this regard. To remediate this situation, CSA prevention programmes must include efforts to improve the relationship and day-to-day communication patterns between parents and children or between children and teachers.

Last but not least, efficacious treatment for CSA survivors would help prevent the victim-turned-abuser cycle from happening, which would be a primary prevention effort for the next generation. Locally, SWD provides such treatment by very experienced and well-trained clinical psychologists. However, no efficacy data is available.

Conclusion

The above discussion clearly points to the need for a multi-level CSA prevention model. By approaching CSA as a public health issue, the corresponding authorities would be able to co-ordinate and oversee preventive efforts at all levels. For instance, the World Health Organization (WHO) has declared child maltreatment a public health concern, and come up with a policy briefing regarding the prevention of child maltreatment in Europe (WHO, 2007). The Centers for Disease Control and Prevention (CDC) identified violence as a public health problem in 1995. Since CSA was considered one form of violence, the CDC convened a panel of experts in 1997, who came up with a list of recommendations to advise the CDC on developing a national agenda for CSA prevention in the US (see McMahon and Puett 1999).

Locally, much good work has been done by individual government departments as well as NGOs on different levels, but the efforts are not systematically implemented or evaluated. Development of CSA prevention is on the whole slow and lacking direction. A central body would be more effective in planning and co-ordinating these prevention programmes. In fact, the Committee on Child Abuse (CCA) is in a very good position to serve this function. The CCA is chaired by the Director of Social Welfare and comprises representatives from related bureaux, government departments and non-governmental organizations. It is responsible for examining the problem of child abuse and mapping out strategies to address the problem. However, in the past years, the CCA has been more focused on family violence and child fatality. Not enough has been done on the prevention of CSA. The preventive efforts would be more focused and consistent if a subcommittee on CSA could be established under CCA, and that a multilevel public health approach was adopted. In addition to firmly grounding the preventive efforts in existing research findings, emphasis should also be put on conducting local research in order to devise prevention programmes that are truly appropriate and effective for the community.

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7

Working with Familial Child Sexual Abuse:
A Family-based Relational Approach

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Overview

Child sexual abuse and child protection should not be perceived only on an individual level in terms of personal trauma, but to be understood with a larger system perspective, with intervention from the legal and social systems. Yet, for the scope of the present chapter, we choose to focus on the psychological effects[2] of sexual abuse on children and adolescents and their families, and on the different therapy modalities in a Hong Kong Chinese setting, bearing in mind the influence of culture, belief systems and values on therapists as well as on clients. We also choose to focus on the complexity of familial child sexual abuse,[3] which is considered to be more disruptive to the child and the family's functioning. A multi-perspective approach is taken in the conceptualization of the problem.

In this chapter, we start by highlighting the importance of understanding the impact of sexual abuse in a family context both from a developmental and a relational perspective. Although the impact of abuse on a child is mediated by an array of factors, very often, sexual abuse in families violates a child's sense of self, as well as disrupts and confuses the child's systems of family relationships. Next, in the section "Local Scenario", we share the challenges and difficulties faced by a therapist in the local context, bringing into focus how helping children of sexual abuse and their families needs to address the complex interplay of the influence of the broader context, the effects of disclosure as well as the impact of abuse. In the section "Core Ideas", we discuss how the five core ideas (a collaborative relationship with the child and the family, thinking beyond problem narratives, social context in the life of problems, feminist-based concerns of power and equality, and double foci on meaning and action) guide us to navigate through the many complex challenges and dilemmas these children and families bring to therapy. Arguing, as do Sheinberg and Fraenkel (2001), that child sexual abuse in a family context is fundamentally a "relational trauma" (as opposed to the view that it is primarily a trauma to the individual child which then may or may not affect the family), we opt for a family-based relational approach. In the final section "Therapy for Familial Child Sexual Abuse", we illustrate the different therapy modalities (individual work, family work and group work) of a relational approach with examples from our practice.

Definition and Conceptualization of Child Sexual Abuse

According to the Procedures for Handling Child Abuse Cases Revised 1998, published by the Social Welfare Department of Hong Kong, child sexual abuse is defined as

> the involvement of a child in sexual activity which is unlawful, or, although not illegal, to which a child is unable to give informed consent. This includes direct or indirect sexual exploitation and abuse of a child by an individual whether inside the home or outside; abuse by parents, or carers or other adults singly or acting in an organized way, or children; abuse which is rewarded or apparently attractive to the child; and abuse by individuals whether known or stranger. (p. 1)

With reference to the Protection of Children and Juveniles Ordinance, Cap. 213, children and juveniles under the age of 18 are covered in this procedure handbook which serves as a guideline for the collaboration between the Social Welfare Department and the Hong Kong Police in the investigation and protection of children and adolescents who have experienced sexual abuse. Child sexual abuse is similarly defined in the West, as all forms of sexual contact between an adult and a child, or between an older and a younger child if significant discrepancy exists in age, development, or size (Berliner and Elliott 2002). The foci are on the incapability of a child to give informed consent, and the use of force, threat of force, or deception in the sexual activity.

Although not totally reflecting the whole picture, official statistics in Hong Kong still indicate the trend on how society perceives child sexual abuse and the readiness of the public to file a report. While only 53 new cases of child sexual abuse were registered at the Child Protection Registry in 1995, 234 new cases were recorded in 2005 (Social Welfare Department 1996, 2006). In Ma, Yau, Ng, and Tong's (2004) study of the 58 sexually abused children referred for psychological service in 1999, 22% of them were not established as genuine child sexual abuse cases in the official registry. The major reasons include: "the evidence given by child is not strong enough to make a case in court", "inconsistent child account", "no corroborative evidence", and "child is too young to give a detailed account". It follows that whether a case can be legally prosecuted is one major factor influencing how professionals (police officers, social workers, and school teachers) decide its nature. It also reflects the inadequate knowledge of some professionals about the complexity of disclosure in child sexual abuse.

The impact of child sexual abuse, especially when it occurs in a family context, goes beyond simple PTSD symptomatology. In general, effects of sexual abuse on children are seen in the disruption of their emotion regulation, behavioural disturbance, cognitive difficulties, interpersonal difficulties, and post-traumatic stress reactions (Berliner and Elliott 2002). In another review of studies on the impact of sexual abuse on children by Kendall-Tackett, Williams, and Finkelhor (1993), several factors were found to lead to more symptoms, including: close relationship with the perpetrator, high frequency and long duration of the abuse, use of force, penetration, lack of maternal support at disclosure, and victim's negative coping style. Symptom expression is also different during different developmental stages of the children. To illustrate, anxiety, nightmares, general post-traumatic stress symptoms, and inappropriate sexual behaviour are more common among preschoolers. School-age children exhibit more fear, aggression, regressive behaviour, school problems, and general mental health problems. For adolescents, depression, self-injurious behaviour, illegal acts, running away, and substance abuse are more common.

The reviews support taking a multifaceted approach integrating different ideas in understanding the traumatic impact of sexual abuse on children. In this regard, both developmental and relational perspectives, which take into account the child's developmental needs as well as the systems of relationships in which he or she lives, are adopted in the assessment and treatment of the traumatic impact of sexual abuse on children.

Developmental and relational perspectives

Finkelhor (1995) suggested distinguishing between localized effects and developmental effects in understanding the impact of child victimization, including child sexual abuse. Localized effects refer to those typical post-traumatic stress symptoms. They primarily affect the behaviours of children and adolescents in relation to the traumatic experience and are relatively short-term. Examples include fear of being around with adult figures that resemble the person who abuses them, and avoidance of places where the abuse occurs. Developmental effects are generalized impacts that interfere with the developmental tasks of the child. These include disruptions of attachment and self-esteem, sexualized or aggressive mode of interpersonal relationships, substance abuse, or self-mutilation. They are more likely a result of repetitive abuse that changes the nature of the child's relationship with his or her primary care takers and/or disrupts crucial developmental transitions. For instance, children who have been sexually abused for a prolonged period may have difficulties in heterosexual relationships when they start dating in the late adolescent stage. Repeated severe forms of abuse may even lead to chronic dissociation as a defense mechanism and alterations of the child's physiological development.

The importance of employing a relational perspective in understanding the impact of sexual abuse is also reflected in Kendall-Tackett et al. (1993)'s review, which indicates that close relationship with the perpetrator and availability of maternal support at the time of disclosure are associated with the severity of the impacts. When sexual abuse is perpetrated in a family context by someone whom the child trusts or relies on, those abuse characteristics such as frequency and duration of abuse and their associations with the severity of impacts assume a different level of meaning (Sheinberg and Fraenkel 2001). By adding a relational lens in the conceptualization and treatment of familial child sexual abuse, particularly incest, Sheinberg and Fraenkel (2001) termed it a relational trauma to the child[4] and the non-offending parent[5] — "disruption in the sense of trustworthiness, openness, and clarity of family relationships, and the emotional turmoil, loyalty binds, and dilemmas that result" (p. ix). Incest is perceived as a betrayal of trust and a disruption of the child's primary attachment relationships in the family. When a child experiences confusion and conflicts in comprehending the abuse as well as the relationships with both the offending and the non-offending parents, such confusions and dilemmas are seen as relational binds and can lead to disruptions in self-perception and interpersonal trust in the child's development.

The Local Scenario

In our experience of working with children who are sexually abused by a close family member, the effects of sexual abuse on a child are often mediated by the response of the family and other communities (extended family, school, neighbourhood, police), the society's attitude towards child sexual abuse, as well as resources and services available in the social and legal systems. Therefore, understanding and locating the effects of abuse in the particularities of the broader context of the child's life (Yau, 2006) is of pivotal importance. In our local context, oftentimes, it is this broader context that adds to the difficulties experienced by the children and the adolescents more than the sexual abuse itself.

Effects of disclosure

On top of the many direct effects of sexual abuse such as secrecy, shame, depression, fear, anxiety, isolation, self-blame, guilt, self-harm, traumatic responses and dissociation, many children and adolescents struggle with the impact of disclosure. In telling, many of them have to face the rejection and anger of family members who blame them for disclosing and for tearing the family apart. The anger and rejection from the family members can further bring about feelings of self-blame and guilt in the children. Self-blame and guilt is sometimes so overwhelming that these brought about acts of self-hate and self-harm in these children and adolescents. It will be further more difficult if these children already have a negative self identity prior to the abuse, such as being treated as a scapegoat or being less favoured in the family because of their gender. The negative identity that the children have about themselves will make it more likely for them to attribute negative meanings to the experience of abuse. For example, they may think that they are responsible for the abuse, or they are useless, inherently bad or unworthy. In turn, these negative meanings may shape their way of expressing the experience of abuse in forms of self-destruction or self-harm (White, 1995), or by engaging in relationship practices that are chaotic or even detrimental to their own wellbeing.

Influence of the broader context on the effects of telling

In our local context, when a child discloses of having been sexually abused by someone in the family, to protect her from further risk of abuse, the child is likely to be removed from her family and placed in a group home setting, with a Care or Protection Order from the Court if the situation necessitates one. Still, the current socio-legal system and the available services would make it very difficult to demand the family member who perpetrates the abuse, rather than the child, to leave home. Many families wish to cover up the abuse, for fear of consequences such as legal prosecution and imprisonment of the offending family member, break-up of family relationships, loss of the tangible and intangible supports of the offending parent, and issues of stigma and shame. In addition, the non-offending family members and the child's attachment or loyalty ties with the perpetrating family member is also another reason for the family or the child to be reluctant to report the abuse.

The ways a family responds to a child's disclosure are very much shaped by their belief systems, and their social and cultural background. Think of a family that comes from a background where they hold traditional beliefs and cultural attitudes towards female chastity. They are likely to see a sexually abused female child who lost her virginity as being ruined, as bringing shame and disgrace to the family, and as losing the hope to marry decently. Or, imagine a family, which holds the gender stereotypes expecting girls to self-sacrifice, to take care of the needs of others before hers, and to tolerate in face of bad happenings (belief such as "girls can only blame the fate if bad things happen to them"). When these families face a female child's disclosure of having been sexually abused by, say, her father, some possible responses may be: to discredit or disbelieve the child's telling, to keep this a secret and an internal family affair, to sacrifice the daughter's needs to preserve the whole family or the family name, or to protect the father's position in the family rather than the child's. Thus, the socio-cultural context shapes and influences how the family would respond towards a child's telling of sexual abuse, and in turn these would have direct bearings on how the child is affected by the abuse.

In the local setting when protection usually comes in the form of providing the child out-of-home care, disclosure can bring tremendous pressure and sometimes be traumatizing to the child. These children and adolescents, though having done nothing wrong, cannot help but feel being unjustly treated and even punished for having told. Many children regret that they tell. They simply long to return home, even if this means returning to live with the person who abused them. Others may become unduly distressed by immense guilt, fear or anger, which may be expressed in self-harm, destructive acts, unstable mental conditions, etc. When these happen, the negative effects brought by the disclosure compound the direct effects of abuse, and bring additional trauma to the child.

Challenges for therapists in the local context

In a nutshell, a therapist working with sexually abused children and families in the local context needs to pay special attention to the complex interplay between the influences of the broader context, the effects of telling as well as the impact of abuse. These often pose particular challenges for the therapist. For a child struggling with some of the aforementioned difficulties of telling, the therapist who sees her distress as some individualized psychological problems is in a way pathologizing the child for problems that are actually brought about by the person who abused her as well as by the broader context.[6] It is important for the therapist to work with the child in ways that locate her specific difficulties in the particularities of her broader life context, so that she does not become the problem. For example, a child may be angry and acting out destructively after her disclosure, because she is disbelieved, blamed, and removed from home against her will. If a therapist only sees her as having some internalized psychological problems in regulating emotion and in anger control, he or she would be grossly minimizing the plight of the child, as well as pathologizing her. The therapist is also doing injustice to this child who in fact has been unjustly treated on two levels: first, by the person who sexually abused her, and second, by the broader systems. If the therapist is able to address and locate the child's anger in her broader life context (the child in fact has many reasons to be outraged given what she has been through), he or she may come to understand the anger differently. Perhaps, it is an outrage of being unjustly treated, and is a way of claiming back a sense of fairness. The issue of anger takes on a whole different level of meaning, and is no longer simply an internalized problem or a deficit. The therapist may, for example, work with the child in ways that honour her anger as a struggle to claim back some sense of fairness, yet at the same time also assist her to express the anger in ways that are not destructive.

Core Ideas that Guide Our Work with Sexually Abused Children and Their Families

There are several core ideas that shape and guide our work with sexually abused children and their families. These ideas are inspired by the work of Sheinberg and Fraenkel (2001), as well as influenced by family systems thinking (see Nichols and Schwartz 2007, for a review of the different schools of family therapies based on family systems thinking; Fraenkel 1997; Imber-Black 1988; Hoffman 1981), postmodernist thinking, in particular social constructionism, narrative ideas and practice (see Hoffman 1993, for postmodernist thinking in family therapy; White and Epston 1990; White 1992; Freedman and Combs 1996; McNamee and Gergen 1992; Hoyt 1998; Zimmerman and Dickerson 1994), and feminist ideas (Brickman 1984; Carter, Papp, Silverstein, Walters 1986; Hare-Mustin and Marecek 1994; Sheinberg 1992; James and MacKinnon 1990). The major ideas are highlighted here: (1) a collaborative therapeutic relationship with the child and the family; (2) thinking beyond problem narratives that only speak of disorders, pathologies and deficits, and attending to stories other than abuse and shame in the families (building up stories of strengths as platforms that allow the family to address and take responsible actions for the abuse); (3) the importance of the social context in sustaining or ameliorating problems related to sexual abuse, in particular, how class, race, gender and culture shape and influence each family members' experience of the abuse; (4) feminist-based concerns of how gender inequality supports a context that facilitates misuse of power within families and societies, often by men towards women and children, e.g. child sexual abuse; and (5) double foci on the family's experienced meaning of the abuse and on assisting them to change patterns of interactions that sustain the negative meanings they have attributed to the sexual abuse.

A collaborative therapeutic relationship with the child and the family

For children and adolescents who have been sexually abused by a close family member, their lives and integrity are much violated. One of the core experiences of abuse is that the child's integrity and sense of personal agency (the ability to affect what happens to her life) are compromised, demeaned and diminished. One adult has exercised absolute power over the child or the non-offending family member to act on his needs and desires, disregarding the child's and the other member's needs and well-being. The therapist has to be aware of his or her position of hierarchy and power, which is unavoidable in the therapeutic relationship, and use his or her power ethically. It is critically important that the therapist not create a context in which the child or the family members have to go through similar experiences of being imposed upon even though the therapist can be well meaning. For example, the therapist may insist that the child talk about the details of the abuse experience in the early stage of therapy, in the belief that this would help to resolve the trauma, while the child does not yet feel emotionally safe to do so. This act of the therapist diminishes the child's sense of personal agency. It also recreates the similar power-over and imposition situation that the child was subjected to in the abuse relationship. The act of going back to the lived experience of the abuse without the child feeling emotionally and psychologically safe also runs the risk of re-traumatizing the child (White, 2005). We take therapy as a journey of respectful collaboration with the child and the family together. The child and the family are actively engaged and invited to give voice to and participate in decision making regarding the content and process of each therapy session as well as the entire therapy — what issues to talk about, who to invite to the sessions, how to work with other professionals, when to talk about the abuse and when to stop, when to do joint sessions, whether the therapy is helpful, etc.

In short, we see that therapy is a respectful and ethical collaboration with the child and the family.[7] The therapist has to be critically reflective of the effects of their beliefs and actions in therapy on the child and the family, e.g. whether they may have said things that subtly put the blame on the child or on the non-offending parent for the abuse rather than holding the person who abuses as fully responsible; or whether they may have made decisions for the family without bringing in the family's own resources, strengths and skills. This would involve many challenges since working with children and families collaboratively requires them to participate actively. In our local context, many of the families may not trust professionals, they would not come for therapy especially since they are not bound legally, or they may have prior negative experience of being treated insensitively by other professionals. Even when family members are involved in therapy, it is still a challenge for the therapist to adopt a collaborative position that on one hand, engages the family to have their own voice and honors their preferences, while on the other hand, attending to the child's safety that has been so blatantly violated.

Thinking beyond problem narratives

Post-structuralists and social constructionists (White and Epston 1990; White 1992; Freedman and Combs 1996; Zimmerman and Dickerson, 1994; Brown and Augusta-Scott 2007) highlight the importance of language, social discourses, and narratives in shaping meanings of events and experiences. Problem-focused language and narratives (descriptions, accounts and theories of individuals and families that focus on their difficulties, dysfunctions and pathologies rather than their strengths, skills, and resources) not only have the effect of internalizing problems of individuals and families, but also limit and restrict the possibility of change. For example, when we speak of a sexually abused child as "a victim", the language denotes the child as a passive recipient to the impact of abuse and totalizes the child's identity as a victim. Post-structuralists see that a child's experience of abuse is but one of the many experiences that shapes her identity. They view identity as shaped by multiple life stories, of which one is the story of abuse. They also construe that identity is fluid, social, relational and multiple (shaped by different experiences, different relations with people, how the child and people in her life context make meanings of different experiences, and the larger culture). Influenced by the narrative and post-structuralist thinking, we also believe that the story of abuse, usually a story of trauma and shame, is not the only life story that shapes and defines the child's identity. There are many other life stories that exist alongside the story of abuse (White 2005). These other life stories speak to the child's identity not just as a victim, but tell about the child's strengths and resources, for example, her skills to survive the abuse, her skills to reach out for help, her know-how to protect her younger siblings from also being abused. When the therapist is able to rediscover and resurrect these other life stories, or the more preferred stories in the child, which speak of her strengths, resources and skills and which she can feel proud of, this assists the child to have a greater sense of personal agency and to come to a more preferred or "positive" conclusion about her identity. This then becomes a platform that makes it more possible for the child to face and deal with the painful realities of abuse and its distressful effects, without running the risk of being re-traumatized. This opens up possibilities for change.

Tung's story[8] illustrates these points. Tung, 15, had endured many years of sexual abuse by her father who was also a tyrant at home, demanding almost absolute obedience and submission from everyone in the family. One of the predominant ill effects she suffered as a result of the abuse was an intense sense of self-hatred, accompanied by depression, which resulted in many incidents of self-cutting. Despite this, Tung did quite well in school, and she was liked by classmates and teachers. The therapist was curious as to how Tung was able to manage so well at school. Not willing to define Tung's identity as a helpless victim, the therapist chose to think beyond the problem narrative that Tung was emotionally unstable (depressed), had poor self-esteem (she hated herself) and had poor coping (she cut herself). The therapist was interested in how Tung seemed to have two different stories (and probably more) going on side by side in her life. One story was that Tung was a smart, responsible, popular and likable student at school, and this story existed alongside the more dominant story of trauma, expressed in self-hatred and cutting. The therapist engaged Tung in a series of conversations that explored, despite the ill effects of abuse, what supported her not to give up and resigned to life completely, what kept her still going at school, as well as the skills she had that helped her to manage so well her schoolwork and relationships with friends and teachers. From this, the therapist assisted Tung to gradually come to a different identity conclusion about herself — that she was not a helpless and powerless victim, but rather, someone who struggled against odds to preserve her dream of a better life. Tung revealed to the therapist that she aspired to attend university, which she knew would make it possible for her to live away from her family and to be free from her father's tyranny, and that therefore, she had to study hard. She also treasured school life because school was a place where she could have respectful relationships with teachers and friends, the kind of relationships she longed for.

As Tung became more aware of the strengths and the skills she had in striving for a better life despite being subjected to a horrific situation, she came to understand that she had used school as a haven to give her strength to survive the abuse. From this different position, Tung came to realize that she had never really surrendered totally to her father's tyranny. She had kept alive her hope and dream for a better life. When the therapist asked Tung whether she had also demonstrated this spirit of not surrendering in the abuse experience, and if so, how, Tung looked back at the abuse experience and began to recall little things she had done that demonstrated her not surrendering, little things that she had not noticed before. She had resisted in little quiet ways. Before, when Tung was very much taken over by the identity of a helpless victim, she blamed and hated herself for being weak and for not having the courage to tell her father to stop, which was why she would cut herself to ease her pain and to punish herself. Being able to recognize her quiet ways of resistance (such as holding her body rigid to make it difficult for her father to have sex with her, or trying to teach her younger brother to keep her father away from her, or negotiating with her father for her to join activities at school so that she had less time at home), Tung came to see her "weakness" differently with a new meaning. She said that it was actually wise for her not to resist openly because this would very likely incur her father's wrath and put herself in a dangerous situation.

When the therapeutic conversations came to this point, Tung was able to relieve herself substantially from self-hatred and self-cutting. In this example, if the therapist had started off by focusing exclusively on Tung's problem story of victimhood (self-hatred and self-cutting), when Tung was already entrenched in a negative identity conclusion and overwhelmed by powerlessness, it would only make Tung feel further worse off. If Tung found herself still unable to change for the better even after discussion with the therapist, she would only sink deeper into a sense of powerlessness and worthlessness, and becoming further trapped in self-loathing and self-hatred.

In short, it is important for therapists not to focus entirely on the problem story of abuse. At the same time, we are not talking about an exclusive focus on the more preferred stories of strengths and resources to substitute the painful story of abuse. The problem story and the more preferred stories exist side by side. Usually when a child and a family come in for therapy, the problem story of abuse dominates their identities. It is the therapists' challenge to collaboratively engage the child and the family to rediscover and richly describe their preferred self-descriptions and to build up more preferred stories of strengths, skills and pride. In this process, the experience of the individual self and the collective self as a family is redefined and co-constructed, and this makes new actions and new experiences of the self possible. The post-structuralists and the social constructionists' emphasis on self and identity as a process of co-construction is important and relevant in our work with this group of children and adolescents, since their sense of self is often much compromised and violated in the experience of sexual abuse.

Re-traumatization versus distress

The story of Tung illustrates one way of working to avoid re-traumatization, as well as the importance to distinguish the two concepts of re-traumatization and distress in working with sexually abused children and their families. In modern psychology and counselling, the idea of going back to the lived experience of the sexual abuse as a way to work through the trauma for healing to take place is commonly accepted. We would like to caution that dwelling on the problem story of abuse exclusively or too early may run the hazard of re-traumatizing the child. When a child has to speak of her sexual abuse experience not in a context of emotional and psychological safety, there is a high chance that she may become trapped in the immediacy of her experience of abuse, that is, she will be reliving the experience again, and as a result, the child will be re-traumatized (White 2005).

We would like to stress that it is the therapist's ethical responsibility to take great care to build in a therapeutic context in which the child would only speak of her experience of sexual abuse from a psychological and emotional safe place. One safety check is to invite the child to participate in the decision of when, what and how to talk about the abuse. A child may invariably experience some level of distress when she is speaking about a painful and difficult subject, but it is a different matter from being re-traumatized and having to relive the whole experience.

Social context in the life of problems

Systems theories (see the different schools of systems family therapy in Nichols and Schwartz 2007; Fraenkel 1997; Imber-Black 1988) view problems of individuals occurring in social context, which may serve to maintain or ameliorate the problems. There are aspects of the broader context that may interfere with healing and recovery from sexual abuse, and there are also aspects that are actual or potential resources and strengths that can facilitate the healing. This fits with our experience of working with children and families struggling with issues of sexual abuse. Therapists have to be attuned to the impact of social class, culture, ethnicity, gender, and religion on family members' experience in general (Imber-Black 1988), and in turn, how these aspects of personhood shape and contribute to how each family member construct and make meaning of his or her experience of the abuse.

For example, one woman felt outraged at her husband for having sexually abused their daughter, as her religion and her family all along taught her that men are head of the household who are to protect and look after the family rather than harm them. Another woman came from a social and family background where she had the belief that women are strong emotionally and have to take care of men by sacrificing and putting aside their needs, wants and rights. Though angry with her husband, she sympathized with him and worried what might become of him if he was to go to prison. She expected her daughter to follow suit and to forgive her father. The role of the therapist is not to challenge those beliefs right away, even though he or she may not agree with them. Instead, the therapist explores with the client the meaning of such beliefs — the origin of the beliefs, how the client is impacted by these beliefs in their life, whether the beliefs are helpful to or limit their choice of actions, whether the client has other more preferred values that are in conflict with their beliefs — to open up possibilities for change.

Feminist-based concerns of power and equality

Feminism highlights how the basic inequality of rights and privileges between men and women in our culture give rise to gender beliefs and expectations that shape many interactions as well as facilitate a context for men to misuse power in families.

Feminist thinkers have critiqued traditional family system therapies for viewing violence and sexual abuse as a homeostatic mechanism that serves to stabilize a family threatened by a key family relationship, e.g., the marital relationship (Carter, Papp, Silverstein, and Walters 1986; James and MacKinnon 1990), or more broadly, for conceptualizing incest as a problem particular to dysfunctional families, the notions of "incest families" as being more isolated, and having diffuse boundaries among members (Trepper and Barrett 1989; Trepper and Neidner 1996). Feminists point out that such systems conceptualizations have obscured the fundamental power difference between men and women in families and societies. Though the difference in power between men and women do not cause sexual abuse and violence, the feminists argue that the power difference provides a context for some men to misuse power for fulfillment of their needs at the expense of others (Brickman 1984; James and MacKinnon 1990). The lack of recognition of the power difference between men and women also leads some systems-oriented therapists to regard incest as primarily caused by the unresponsiveness of the female partners to the emotional and sexual needs of their male partners, and also to their daughters' security and emotional needs.

In addition, some systemic formulations also link the mother's deficits as partner and as parent to her family-of-origin experiences — for example, the notion that the mother's difficulties protecting her child once she knows about the abuse may be influenced by her own childhood experience of sexual abuse. Feminists would critique this formulation as ignoring the social and cultural context of patriarchy and how this affects a woman's choice of partner and ways of mothering. For instance, a woman who grew up in a patriarchal family is taught to be submissive to males, and she learns that she cannot and should not stand up for herself. In turn, these beliefs affect her choice of partner, her parenting practices, as well as her degree of fear about stopping her partner's abuse.

Most importantly, feminism critiques systems theory for failing to hold men accountable for the abuse whatever the circumstances, arguing that men who abuse choose to respond to the circumstances and their feelings by exerting power over others. This is the ethical stance we adopt in our work with abused children and their families. In this perspective, the perpetrating family member must hold complete responsibility for the abuse, whatever the family dynamics or circumstances (see Goldner 1998 and Goldner 1999 for an explication of similar idea as related to domestic violence). The challenge is how to uphold this stance, while still working collaboratively with the child and the family to address the many confusing dilemmas and difficult effects of abuse. Feminism provides a clear moral perspective regarding who is responsible for the abuse. This foundation also comes from our belief in values of equality, justice and respect in relationships.

Influenced by feminist thinking, we also hold the idea that gender beliefs, such as what it means to be a man or a woman, affect experience and relational behaviour (Herman 1981; Brickman 1992; James and MacKinnon 1990). We are not saying that particular gender beliefs about power directly cause abusive behaviour. Rather, certain gender beliefs, together with other factors, facilitate such behaviour; thus, in therapy with men who perpetrate abuse, a change in these gender beliefs could reduce the likelihood of abuse. Take the example of a man who has sexually abused his daughter. He may hold the stereotypical gender belief that for a man to be a man, he must not express vulnerability (e.g., feelings of pain, or need for care) nor exhibit any "female" characteristics (such as being dependent, or being empathic and taking care of others). He may objectify women and view them as secondary to men. We believe that to create more long lasting change in such a man's abusive behaviour, it is essential to create a context in therapy to invite him to examine the rigid stereotypical beliefs that have sustained his abusive acts, so as to bring about a change towards more flexible images of manhood, in his definition of masculinity, and in his view of women.

Double foci on meaning and action

Influenced by social constructionist and post-structuralist ideas, we have emphasized the importance of stimulating shifts in experienced meaning in facilitating changes in the child's and the family members' perceptions, beliefs and feelings about the abuse. These shifts in meaning are critical in order to facilitate changes in actions that enable the child to reclaim her life from the negative effects of abuse (Wright, Crawford and Sebastian 2007) and enable the family to provide her safe and nurturing family relationships. Narrative therapy (White and Epston 1990; White 1992; White 2005; Freedman and Combs 1996) suggests that preferred meaning and stories cannot be strengthened without interweaving a person's preferences, values, and beliefs with his or her actions across time. From systems thinking, we recognize the power of patterns of interactions and actions in sustaining meanings (e.g., the child's acting out behaviours may invite criticism from other people, which further reinforces her belief "I am unlikable and unlovable", a meaning she had constructed from the experience of abuse). The change in behaviour and action also helps the family to have different experiences and establish new meaning. Nevertheless, rather than doing in the traditional systemic way, that is, to interrupt or alter repetitive and unproductive behavioural sequences among family members by giving directives, we prefer to engage the family to participate collaboratively for discussion on a problematic pattern, such as sharing with them our observation and exploring with them the pattern's meaning for them, where this pattern comes from, and the family's preferences about it. In short, meaning and action are inseparable, an idea important from both systems thinking and narrative ideas. Meaning shapes action and vice versa; thus it is important that we work with the child and the family on both levels.

Therapy for Familial Child Sexual Abuse

Rationale for a family-based relational approach

As noted earlier, when a child is sexually abused within the family, the trauma is not just about physiological and psychological symptoms, but is also a relational one (Sheinberg and Fraenkel, 2001). She faces confusions and dilemmas, both in her sense of self as well as her relations with other members in family. The child struggles with many relational dilemmas such as whether to tell or not to tell, if she would be believed or blamed, how to make sense of the relationship with the parent who abuses her but also takes care of her, and how to relate with the other parent who is torn between her and the family member who abuses, etc.[9] The experience of being sexually abused by someone close in the family is fundamentally a betrayal and disruption of the trust and the attachment bonds between the child and her parents or caretakers. Such disruptions would negatively affect the child's internal representations of self and relationships with others. Re-building the trust and the attachment bonds between the child and the non-offending parent or other supportive adult figures is therefore crucial to ensure that the family will become a secure base again for the child to develop trust and a positive sense of self.

Similarly, the non-offending parent struggles with how to make sense of the sexual abuse, how to see herself as a wife and a mother, mixed feelings and competing loyalties towards the child and the perpetrating family member, and whom to disclose. All in all, how can justice, fairness, respect, and integrity be upheld and regained in a situation in which the family is haunted by shock, shame and guilt? To address these complex relational challenges, we choose a family-based relational approach with different therapy modalities to work with children of sexual abuse and their families. Here, the idea of "relational approach in family therapy" from Sheinberg and Fraenkel (2001) in their work with families of incest is adopted. The key concepts and considerations in working with families would be discussed with applications in the local context, illustrated with examples from our own clinical experience.

Therapy modalities

In the coming sections, we would discuss the relational approach in terms of different therapy modalities, namely individual work with the child, family work that strengthens the child's relationship with her non-offending parent and that fosters the family to be a safe and nurturing place, and group work that helps to break down the sense of isolation and stigmatization often experienced by children who have experienced sexual abuse in families.[10] These therapy modalities are inter-related components. A therapist would interweave different modalities in his or her work with the child and the family, depending on the circumstances, the family's needs and the issues he or she is working with the family.

Therapists' gender consideration

While research findings in gender-related variable in therapy are varied, a brief review by Tyagi (2006) suggested that the interaction effects between therapists' gender and other factors such as skill level, social roles, and treatment modalities are important in the success of therapy. In the context of family child sexual abuse, the therapists' gender may have an effect on the therapy process. For instance, in individual and family sessions, therapist of the same gender would facilitate the development of a secure context where the child or the adolescent feels safe to share her abuse experience. It also allows her to identify with the therapist and model after her in role identification.

For group sessions, a co-therapy team of mixed gender is preferred whenever possible. It helps members to have experiential learning on the positive interaction between both genders and have the expanded experience that men can be supportive and caring (Fraenkel, Sheinberg, and True 1996). If co-therapy is impossible, again, a same-gender therapist is preferred.

Individual work with the abused child

Goals of individual sessions with the child

In a family-based approach, individual work has its place, purposes and relevance. The primary goals are twofold: to assist the sexually abused child to overcome and reclaim her life from the negative effects of the abuse; as well as to develop safe and nurturing relationships in the family.

When the relationship between the non-offending parent and the child is strained (the parent may be angry with or blame the child, or feel guilty about the abuse), the child may feel uncomfortable and constrained to talk freely about her experience and feelings associated with the abuse in the presence of the parent. The individual sessions with the child serve as a forum whereby the child can clarify and freely express her feelings, thoughts and struggles, and discuss why she finds it difficult to talk about these issues with her parents. The therapist will interweave information from the child's individual sessions (after discussion with the child at her full knowledge of what to share) with the family sessions. The goal here is to strengthen the child's relationship with the non-offending parent, so that the parent can support and protect the child.

In the local context, oftentimes the therapist is only able to see the child without participation from the family. There are many reasons that the non-offending parent, apart from not being legally bound to do so, does not come for therapy. She may feel too shameful to talk to an outsider about the sexual abuse; she may be angry with the child for the disclosure; she may not believe the child or see therapy as helpful for them; or she may still be very much dominated by or dependent on the offending family member financially and emotionally, and dare not do anything to rock the boat further such as going to see a therapist, etc. In extreme cases, the child may even be rejected and ostracized from the family. To reduce the child's sense of isolation and disconnection from the family, the therapist may have to seek out the child's other support networks, such as inviting other significant supportive figures, a teacher, a house-parent, a friend, perhaps, to the sessions. Sometimes, the therapist may have to find ways to evoke and enrich the presence and positive influence of these other significant people who cannot be physically present.

At the same time, the therapist also needs to strengthen the child's sense of personal agency and help her regain a positive identity. When the child experiences significant distress or difficulties as a result of the abuse and the disclosure, the therapist needs to find ways to assist the child to overcome and get her life back from the difficulties. We wish to emphasize again that we prefer to collaborate with and support the child to discover and connect with her strengths, skills and resources than to teach or direct the child.

Besides, young children, because of their language and cognitive development, may not be capable of articulating their distresses and concerns through words adequately. Therapists have to adapt their ways of working to fit a young child's development and needs. Individual play therapy can be a helpful alternative to facilitate children's expression of feelings, confusions and thoughts. Sometimes, children generate creative solutions in the process of play therapy. Thus, therapists who wish to work with young children may consider equipping themselves with play therapy theories and techniques. Gil (2006) has proposed to integrate directive and non-directive play therapy approaches in working with abused children.

Some examples

We would illustrate our individual work with the abused child with two examples. The first story is about a young child who struggled with significant level of distress following disclosure, even though she had a mother who believed and supported her. In the individual work with this child, the therapist had adapted the relational approach to include some play therapy techniques to fit with the child's age. Next is a story of an adolescent girl whose family members did not believe and support her. The girl experienced much difficulty after the disclosure and the therapist had to find ways to enhance her sense of personal agency and overcome the negative effects of the abuse.

Individual work with young children

This is the story of Mei, a 6-year-old girl, who was sexually abused by her father. The abuse happened two years ago and lasted for a year. She only disclosed the abuse after the mother, Kwan, separated from the father. A report was made to the police but she was so fearful and embarrassed that she was not able to describe the incidents in detail. The police eventually dropped the case. When the father requested access, Mei was highly distressed. She was afraid to see her father. The mother was also scared as Mei's father was verbally abusive and had harassed her numerous times. Mei had bad dreams, and refused to eat and go to bed. She became irritable, threw temper tantrums, hit and bit her younger brother, let her school grades deteriorate and sometimes even refused to go to school. Kwan did not understand why Mei had become so difficult and uncooperative. She coaxed her, reasoned with her and scolded her but was to no avail. Kwan felt helpless and incompetent as a mother when she brought Mei into therapy.

Mei was a smart and articulate little girl, but in the early stage of therapy, she made it clear that she did not want to talk about the abuse incidents. Mei was invited to express her feelings towards the sexual abuse through expressive play therapy techniques, such as drawings and artwork. It was clear that she struggled predominantly with anger and fear. Yet, Mei did not want to say more about what she was angry and fearful about.

The therapist talked with Mei about the Anger and the Fear as if they were separate entities in Mei's life. The therapist asked questions such as what the Anger and the Fear were doing to Mei's life, how Mei thought about the Anger and the Fear, whether she liked or disliked them, and what she wanted to do about them. The therapist invited Mei to draw pictures of what she thought the Anger and the Fear looked like. The therapist was talking in ways that externalize and separate the problem of Anger and Fear from Mei.[11] Through this kind of talking, the therapist helped to create some space and distance between Mei and the problem, so that it was easier for Mei to get access to her strengths and resources to deal with the problem. The therapist did not see Mei's identity as defined solely by the problem of Anger and Fear (thinking beyond the problem narrative) but was interested to learn more about Mei's strengths and resources that she could use to deal with the problem.

With the help of Kwan, who supplemented information and filled in details, Mei expressed that the Anger made her throw temper tantrums, hit her brother, and the Fear made her unable to sleep at night, and reluctant to go out, including to school. She did not like the Anger and the Fear's company in her life, because they made her feel bad about herself, and also made every one unhappy at home. At this point, Kwan described what Mei was like before. She told little stories of how Mei was a conscientious, caring, helpful and responsible little girl. Then the therapist asked this question, "Mei, you said that you don't like the Anger and the Fear cling close to you, because they make you feel bad about yourself and every one unhappy. Have you got any ideas on what may be a good way to get rid of them in your life?" Mei thought for a while, and then said that the best way would be to change them into Happiness. The therapist then invited Mei to use some miniature toys to show what a happy life would be like for her. Mei liked the idea and was very involved in making what she subsequently named the Happy Kingdom, which she built in a sand box using miniature toys. In this Happy Kingdom, there was a birthday party with food and balloons, some children were playing happily, a fairy was watching over and there were lovely flowers and a rainbow. Then Mei and the therapist talked about what would be some happy activities for her (the double foci of both meaning and action). Apparently, after the construction of the Happy Kingdom, Mei was able to express more about the Anger that was bothering her. She wrote on the white board the name of her father, then she wrote "bad guy". The same night at home, Mei told her mother that she would be happy if the police caught all the bad people. She also asked her mother why her father could walk away without any consequence despite that he had done bad things. This helped Kwan to see Mei differently. She shifted from seeing Mei as difficult and uncooperative to seeing Mei as being angry because she felt so hurt by what her father had done, and because she felt so unfair that her father could get away without any consequences.

In the following weeks, Mei did gradually turn Anger and Fear into Happiness. She told the therapist that she had moved to live in the Happy Kingdom. She said that as long as she did the good things that she used to do, she could shut out Anger and Fear from the Happy Kingdom. She and her mother then gave the therapist a list of the good things she did, including studying hard, eating meals, going to bed on time, engaging in happy activities (reading story books, playing on the computer, playing with her brother) and talking to her mother. At this juncture, the therapist was interested in fostering a different sense of identity for Mei. When the therapist asked what it meant for her to be able to regain happiness after so many difficulties, Mei said that this must mean she was a happy person, as a happy person would try to be happy even when things were bad. Kwan joined in and told the therapist that actually the family used to nickname Mei "Smiley" when she was small, because she had those abilities to bring happiness to people around her, and Kwan gave many examples. The meaning of being "Smiley" was interweaved with daily examples of actions (double foci of meaning and action). Kwan's sharing helped to enrich and reinforce this happy self that Mei was re-discovering in herself, and obviously a more preferred self for Mei. As a ritual to commemorate Mei's rediscovery of this more preferred identity, "Smiley", the therapist invited Mei to make a citizenship card of the Happy Kingdom for herself. Mei was enthusiastic about the idea. She eventually designed one for herself, one for her mother and one for her little brother. She proclaimed that she, her mother and her brother were the first three citizens in the Happy Kingdom!

In the next session, Mei came in and announced that she wanted to draw pictures to show the therapist and her mother what her father had done to her. She had never told the incidents in full before. Mei was a bit embarrassed, but she felt proud of herself in being able to tell, through drawing, what had happened. Apparently, the happy identity had made it possible for Mei and given her strength to tell the abuse incidents. Kwan's changed understanding of the meaning of Mei's anger was also pivotal in changing the way she responded to Mei's "uncooperative behaviours" at home. Kwan was more supportive, patient and understanding.

Unfortunately, when things seemed to get better, the court requested the social worker to arrange for access of the father to Mei. Mei's distress level intensified after she met the father under the social worker's supervision. She was unwilling to go to school again, vomited if made to eat, shivered, was jumping around, and was unwilling to sleep. Eventually, Mei confided to her mother that she had to keep moving around and making sounds, because if she quieted down, she would see scary things. In the session, the therapist had some externalizing conversations with Mei on the scary things. Supported and encouraged by the mother, Mei was eventually able to tell them that she saw a dark human shadow with no hands and feet, usually before she went to sleep or when it was quiet all around. The therapist then asked Mei, "Where do the scary things appear, in your mind, or before your eyes like I am sitting in front of you now?" Mei replied that the scary things appeared inside her head. The therapist and Mei then had some discussions on whether the scary things were real or not since they only appeared inside Mei's head, why they would want to keep Mei afraid, what they were up to by tricking Mei into believing that they were real, whether they had any real power to hurt Mei, etc. Instead of telling Mei not to be afraid since the scary things were only images in the head, the therapist gave Mei the space to figure out on her own that they were not real. The externalizing conversations also made it possible for Mei to discover that as long as she was not afraid, the scary things had no real power over her. With the assistance of her mother, Mei came to the conclusion that she must have a smart brain to be able to see through the tricks of the scary things and figure out that they were not real. This preferred identity of Mei, as someone with a smart brain, also made it possible for Mei to make the decision, at the end of the session, that she would not let something unreal mess up her life.

After this meeting, the scary things reduced their appearance in Mei's life significantly, but Mei was still hitting her brother. At this point, Mei was able to articulate clearer what she was angry about. Mei asked forcefully why someone could do bad things and did not need to face any consequences, why she had to be good and considerate so as not to make others unhappy while that person (referring to her father) did not need to care for people, and what the point was for her to be a good kid. It was clear that Mei was angered by how unfairly she was treated. She was angry that her father denied the abuse, accused her of making things up, and even harassed her mother. She was also angry that not only did the adults and the police do nothing about her father's abuse but they made her see him against her will. Having understood the meaning of Mei's anger, the therapist was curious what might be important to Mei that was taken away by the abuse and by the way the abuse was handled, which led to her outrage. Kwan, at this point, was really good at reading beyond the problem and understanding the meaning behind the problem. She said that Mei really valued being fair and responsible, and the abuse violated these important values of hers. Kwan gave some daily examples of how Mei would keep her words, how she tried to play fair in games and treat her friends fairly, how she was willing to accept discipline when she did something wrong, etc. Kwan's descriptions acknowledged Mei's outrage. Kwan added that she and Mei's teachers all liked these qualities of Mei and it would be a real pity if Mei let the Anger take away her precious qualities. With the help of the mother, a more preferred identity of Mei being a fair and responsible child was rediscovered and developed.

Very amazingly, several days after this session, Mei told her mother that she would not be so stupid as to fall for the trap of Anger, and let Anger make her sick (vomiting, not eating or sleeping) and unhappy. She also would not let what her father did to her ruin her life and make her unable to do important things, such as going to school, taking care of her own daily routines, doing happy things, and being a nice sister. It seemed that Mei was able to use her smart brain to figure out ways to transcend the anger so that she could continue to have a happy life. She was living out the several preferred identities that she, her mother and the therapist had talked about — being a conscientious, caring, helpful and responsible child, being a happy person ("Smiley"), and being someone with a smart brain.

Although the individual work with the mother is not the focus in this section, suffice to say is, Kwan came to realize that she had also let fear dominate her attitude towards her ex-husband. Fear had interfered with her commitment to protect Mei. Mei's courage in telling the abuse incidents had also inspired Kwan to be courageous to fight for herself and her daughter if they wanted a happy life. She was determined to take action in the court to fight for a fair share of property (before, she had planned to ask for nothing from her husband) and to apply for temporary suspension of her husband's access, even though she knew that he would be angry and perhaps retaliate. As a passing note, the therapist also liaised with the social worker on the issue of the visitation. The therapist worked with the larger system to advocate for Mei's interests. Eventually, the court granted temporary suspension of access. A few months later, Kwan succeeded in obtaining her ex-husband's consent through the court and took the children abroad to study.

Individual work with children whose relationship with the parent is strained

For children whose parents do not fully give them support and blame them after the disclosure, and for children whose family members do not participate at all in therapy, the therapist has to face many challenges. The hardest challenge is how to work with these children, who are isolated, unsupported, and disconnected, in ways that would help to foster a greater sense of personal agency and reconnect them with supportive figures.

Sui was 15 when she disclosed the sexual abuse by her father to her friend. The abuse had started since she was 9 and progressed to sexual intercourse when she was 13. Sui was worried about being pregnant and she decided to tell a good friend about the abuse, after much struggle. To cut the story short, the abuse was eventually reported to the police and subsequently the father was charged. Sui's mother did not believe in Sui's accounts. She believed that Sui had sex with her boyfriend and then made up a story of sexual abuse by the father to protect herself from being reprimanded or beaten up by the father. The mother and the two younger siblings were angry with Sui for accusing the father and believed that he was innocent. Sui was the only person whom the therapist could see because the family members refused to participate in therapy.

After the disclosure, Sui had to live in a children's home. She was under undue stress for being disbelieved and blamed, as well as having to leave home. Feeling lonely and rejected, Sui tried to kill herself by swallowing sleeping pills. Sui was referred for therapy after she was discharged from hospital. Sui told the therapist that she came to know an older girl called Ki in the children's home. Ki had a similar experience to Sui's, and her story inspired and changed Sui. Sui said that Ki's mother also disbelieved Ki, and they had limited contact since the disclosure. Though this was hurtful to Ki, Ki had strived to establish her own life and worked hard to fulfill her dream — she hoped to be a nurse some day. Ki's story gave Sui hope. Ki told Sui that the most important thing was that she ended the abuse by telling somebody. Ki further said that if she could go back in time, she would have told earlier. The therapist asked Sui what was inspiring for her from Ki's story. Sui reflected that Ki's strength and courage to survive the abuse and to build a life of her own touched her. The therapist then engaged Sui in a discussion around the following questions, including in what ways Ki's story had touched her and why, why she agreed with Ki that stopping the abuse was the single most important thing, how her life would be different without having to endure the abuse, what kind of life she wanted for herself, etc. The therapist hoped to assist Sui in expanding the meaning of the experience of disclosure through her resonance with Ki's story.

Sui's telling of the abuse no doubt brought pain and loss, but it also said something about Sui's resolve to stop the abuse, the skills and strengths she must have to make and put the decision of telling into action, and the hopes she had for her future life. In the conversations, Sui came to realize that she wanted a life that she could make free choices, and to live with respect. She did not want to be forced to do things she resented. Sui knew that her father would not have stopped if she had not disclosed, and her telling was pivotal in bringing an end to the abuse. For Sui, the disclosure now assumed an expanded meaning. It marked a significant step of her taking her life back into her own hands. She no longer needed to be subjected to her father's selfish needs. Though she was saddened and hurt by the family's response, she believed that she could still have a life if she did not give up on herself, just as Ki did. When Sui was able to expand the meaning of the disclosure, she had more personal agency. This was reflected in a concluding remark she told the therapist. She said that she would not think of dying again even though the circumstances were still tough, and thinking back, she knew she had made the right decision by telling someone about the abuse.

As Sui gradually adjusted to the life in the children's home, and her mother and siblings also resumed some contact with her, she was doing better. However, as the court date drew near and Sui had to take the witness stand since her father did not plead guilty, anxiety and guilt got an upper hand in Sui's life. She had the dilemma of whether to withdraw from being a witness. On one hand, she felt worried and guilty upon seeing her mother's and her siblings' distress about the father's possible imprisonment. Sui was especially worried about her mother who had weak health. On the other hand, Sui was also very angry at the father's denial. She felt it was unfair that her father got all the sympathy while she was blamed and rejected by the family. She very much wanted to gain some justice through the court's ruling. This time, although Sui was under a high level of distress facing the pending court hearing, she firmly told the therapist that she would not harm herself as a way out.

Nonetheless, the high level of distress had real effects on Sui's daily life. She had trouble sleeping at night and had bad dreams, felt she was stared at when she went out, and heard voices calling her name. Sui was worried that something might be wrong with her. She was most troubled by the "voices", which disturbed her daily routines. Sui was referred for a psychiatric consultation. The psychiatrist reassured her that she was just being stressed because of the circumstances and there was no need for medication. This was relieving for Sui, but she still wished to discuss with the therapist how to deal with the voices.

Instead of giving advice to Sui on how to deal with the problem, the therapist tried to engage Sui in conversations that would assist her to discover her skills and strengths to cope with the problem (enhancing Sui's personal agency and the belief that Sui was not just a passive victim). The therapist explored the effects of the voices on Sui's life, her reactions to them, the times when the voices would be stronger or weaker, the power the voices had over Sui's life, etc. Sui gradually realized that the voices were able to affect her because she chose to listen and attend to them. It came down to a matter of her choices of how she wanted to attend to the voices. She was certain that the voices were just inside her head and if she chose to ignore them, they would not affect her much in her daily routines. She felt that she could just treat them as noises.

In the following session, Sui told a funny story of how she thought that the voices were calling her again while she was reading a book and therefore she ignored them, only later to find out that the houseparent was really calling her name from the living room. Sui had a good laugh together with the houseparent. Sui discovered that the voices could not disturb her when her mind was fully engaged, which was when she was solving mathematical problems. She even jokingly told the therapist that she had to thank the voices for helping her spend more time to study mathematics. After these conversations, the voices, though still present in Sui's life from time to time, appeared less often, and were less disturbing. Sui also slept better at night.

Sui still struggled with the dilemma of whether to appear as a witness in court. One week prior to the court date, Sui ran into her father when she went back home to get some personal items. The father scolded Sui and told her to leave. Sui was very angry and began to question whether it was worthwhile for her to make sacrifices for a man who had not showed the slightest hint of remorse. The therapist did not take Sui's anger for granted, but explored with Sui the meaning of her anger in the hope of opening up conversations to rediscover Sui's preferred life story alongside the story of abuse. For questions such as what made her so angry at her father's response, why this would have her rethink about taking the witness stand and plan to withdraw as a witness in court, and whether the anger might be related to some important beliefs and values of hers that were being violated by her father's act, Sui pointed out that it was important for her that people should be responsible for their actions. She continued to talk about why responsibility was important because her father had never been responsible to the family and he often put his own needs first. She saw how hard her mother's life had been to support the family. Sui was able to acknowledge her mother's contribution to the family by being a responsible wife and mother. She began to link the value of responsibility, which she held as important, to her mother's influence on her. This subsequently had the effect of softening Sui's anger towards her mother for not believing and supporting her. The therapist asked Sui if the value of responsibility had any relationship with her belief that one should make choices for one's life. Sui, after thinking for a while, agreed that the two were related. She explained that the true meaning of making choices for one's life also included the notion of bearing responsibility for the choice one had made. The therapist and Sui had more conversations around this further reinforced preferred identity of responsibility and making choices for one's life.

As Sui talked more, she realized that actually disclosing the abuse was not the first time she made choices for her own life. She had a history of doing this, such as choosing to enroll in her present school despite her mother's opposition, dating her boyfriend though her parents were opposed, opting for the science stream though her teachers thought that her grades were not good enough, etc. After a while, the therapist asked Sui this question, "So, you have made choices at different points in your life, and you have stood up to opposition and disapproval from others to live out your choice. You also value taking responsibility for one's action. Now, what if you use this value and this belief as guidance in your dilemma about whether to be a witness in court next week? What are your thoughts?" Sui very quickly responded that her father should take responsibility for what he had done. Sui was still worried if her mother could take the blow of her father's possible imprisonment, but she could better differentiate that it was her father's actions which had caused her mother's suffering rather than hers. Sui decided to take the witness stand.

As an ending note, Sui took the witness stand, as she said. She was proud of her performance as a witness, especially her ability to outsmart the defense attorney without falling into the traps of his tricky questions. Eventually her father was sentenced to 4 years' imprisonment. Sui also took a more understanding and compassionate stance towards her mother. She could appreciate what her mother had done for the family, and gradually was able to let go of her anger towards her mother. In a few months' time, the mother also let Sui stay with the family for home leave.

Summary

In working with children who struggle with significant level of distress as a result of sexual abuse and the disclosure, the first and foremost consideration is to build up a secure and safe care-giving environment for the child. This would enormously help the child recover from the trauma of the sexual abuse, and would also safeguard the child from being re-abused again. If the child is still at risk of abuse, there is no way she can overcome whatever difficulties she is experiencing. However, in the local setting, the non-offending family members are often not available for therapy. The therapist then has to explore, invite or invoke the presence of other supportive figures, and work to build up the child's connection with these other persons. This helps to mitigate the negative effects of the abuse. Secondly, the individual work has to address and enhance the child's sense of personal agency. When the child sees herself differently in the preferred life story of resources, strengths and skills, there are more possibilities for change and for expanded meanings of the experience of abuse. The preferred life story then becomes a platform and makes it more possible for the child to break away from the distressing effects of the abuse. Thirdly, the therapist has to be flexible in working with children. For example, when working with young children, the therapist has to adapt his or her ways of working with more child-friendly methods so as to fit with the child's developmental needs.

Family work

Goals of family sessions

The major goals of family work are, firstly, to strengthen the relationship between the child and her protective family members, such as the non-offending parent or other adults who assume the parental role in the child's life, and secondly, to make safe the relationship between the child and the offending parent. When working with the family, it does not mean that the whole family has to be seen together in every session. Individual work with the non-offending parent is indispensable. In this section, the focus would be on individual work with non-offending parent and conjoint therapy with the family.

Individual work with the non-offending parent

Disclosure of child sexual abuse in a family can be equally shocking and confusing to the non-offending parent, usually the mother in most cases. The emotional turmoil around the abuse allegation, the protective role of being a mother, the attachment towards as well as the sense of betrayal by the partner, the possible split-up of the family, the financial and social changes, and the blame and pressure from relatives or family of origin are all real challenges to the non-offending parent.

For a non-offending parent, a common response in hearing the abuse for the first time is shock and disbelief. A mother, Li, shared that when, in the presence of teachers, her 15 year-old daughter, Ling, told her about the sexual abuse by the father for 2 years, her first thought that came to mind was, "This is impossible", and she immediately yelled at her daughter, "Are you insane to say such a thing?" In therapy, she talked about her regret in having said so. When she came to realize how difficult it was for her to face this other side of her husband, who had been a dutiful husband in her eyes, she realized it must also be difficult for her daughter to disclose. Li's husband was arrested and detained. Li had to face many dilemmas. On one hand, she had to cooperate with the social service agency to perform her protective role as a mother. On the other hand, she faced considerable pressure from the father's family, who accused Ling of telling lies and pressed her to recant. Li, who grew up in the same village as her husband in mainland China, felt shameful in facing her own family when the news was made known to them. In addition, her emotional attachment to her partner was real but difficult to be openly acknowledged under these circumstances. At the same time, she was angry with the daughter for first telling the abuse to the teacher instead of to her. She read this as a sign of the daughter not trusting her and she felt shameful to be informed by Ling's school teacher. The beliefs that "family matters should be resolved within family" and "one should never be involved with the court/legal system" are common among Chinese people. She was torn by the split loyalty between her daughter and her husband and the issue on whom she should believe and trust. Though Li had not revealed her dilemmas and struggles to her daughter, Ling was aware of her mother's reservation in believing her. She took her mother's yelling as a sign of not trusting her.

In the sessions with Li, she talked about her shock and disbelief of the abuse allegation, and her trust towards her husband. At the same time, she also had a voice in her head that her daughter was unlikely to lie about this. In listening to her struggles, the therapist explored with her the history of her marriage. Li then told her love story in China before getting married. She talked about how she gave up her love in order to be filial to her parents and came to Hong Kong to marry the present husband under arrangement. She saw herself and her husband as dutiful parents and she gradually became emotionally attached to him. After sharing this part of her life story, she told the therapist that she had almost forgotten this love and the therapist was the first person whom she had told after all these years. In the sessions, her belief in true love and her emotional connection with her husband were acknowledged. This gave her more strength to face the hurt and the betrayal brought by his abusive acts towards their daughter. She told the therapist that she regretted for not holding on to her belief in love, and for having blindly followed her parents' arrangement in marriage. She did not want her daughter to follow the same path, but to be self-determined in finding her own love and happiness.

Through conversations with the therapist, Li told stories that covered the topics of womanhood, filial piety, parents' duties, and beliefs in marriage and love. Gradually, she regained her pride as a woman with strength and responsibility despite that she found herself married to "the wrong guy". When her preferred identity and the values that she had all along treasured were reassured and affirmed, Li had more capability to understand the trauma that her daughter had suffered and what would have happened to her if she had kept the abuse secret for the sake of "filial piety" and for fear of family change. Li also had more capacity to get in touch with her daughter's struggles in the same dilemma of facing parental love on one hand and abuse by the father on the other hand. Li became more receptive when the therapist helped her to understand her daughter's choice to tell the teacher of the abuse. Subsequently, she was able to tell her daughter about her regret in yelling at her. She also decided to divorce and was determined to resist the pressure from her husband's family.

To solicit the non-offending parent's support for the daughter, the therapist has to validate her conflicts in facing the betrayal of her husband as well as her attachment towards him as her lived experience. For Li, it was difficult to share with others her concern for a man who sexually abused their daughter without anticipating shame and disrespect in return. If she told others of what had happened, she would likely get a story of shame, in that she had chosen a "wrong guy" as her husband, or she could not "satisfy" him as a wife. "Married to the wrong guy" is considered one big failure for women in Chinese culture. When sexual abuse occurs in family, one common attribution is that "the couple has problem in their sex life" or "the wife cannot satisfy her husband in sex". The therapist has to be careful of beliefs that subtly justify men's abusive behaviour by blaming women. In Li's situation, the therapist and Li together explored and examined her beliefs in gender, family hierarchy, marriage and love; and how these beliefs were related to her sense of shame. Moreover, the therapist also worked with Li on issues of anger and shame in relation to her daughter's disclosure to people outside the family, before Li were able to understand and support her daughter emotionally.

All these issues are better worked with the non-offending parent individually. This can relieve the child from the pressure of listening to her mother's angry and blaming remarks. In working with the non-offending parent, the therapist has to face the challenge of listening to her perspectives and acknowledging her struggles in her relationship with her partner without losing the stand that the offending partner has to take full responsibility for the abuse. The therapist must not collude with the non-offending parent's attempt to deny or minimize the abuse, but has to listen to, make explicit and examine carefully the beliefs, the attitudes, and the fears that may have supported her minimization; and this would provide the ground for further exploration of the possibility for change.

Another important area of therapy is to understand the non-offending parent's childhood experience with her own parents. This helps the non-offending parent to understand how her parenting practices are affected by or modelled after her experience with her own parents, so that she can make a conscious choice in her current parenting practices. When Li was asked of her early life experience, she talked with fond memory of the care she had received from her mother in mainland China. She also told what she had heard and seen as a child about her grandmother and her mother who, like many women of their time, had lived under hardship. It was discovered that both her grandmother and her mother had to shoulder the burden of caring for the whole family when their husbands were away from home during hard times in China. She told stories about how tough they had been and how they had never given up on their children. In appreciating their strengths and validating their stories as women with pride, the mother reconnected with their spirit; and was determined to continue their legacy and not to give up on her children. Li worked hard as a cleaning worker to support the family financially and to take care of her children. From this, the therapist reflected that she was in fact a lot like her mother and her grandmother; and further asked Li how she would like to help her daughter learn to be a woman with pride and strength. Li responded that she wanted to tell her daughter the stories of women in her family line and her determination to take care of the children. She hoped that Ling would never give up her dreams even in hardship. Meanwhile, Ling was also seen separately for her adjustment after the disclosure and her perception of the abuse; the details are not within the scope of this section.

In working with the non-offending parent, we find that asking "If" questions are helpful to bypass the denial or the minimization, to expand the mother's perceptions and to assist her to get in touch with her emotions that are difficult to express. For instance, instead of falling into an argument with the mother, the therapist may ask "If the abuse had really happened, what do you think would be the consequences? How would you and your daughter be affected?" Sometimes, not all non-offending parents are like Li, ready to make a moral choice. Some simply refuse to trust their daughters and participate in therapy. When working with the non-offending parent is impossible, other supportive adults have to be identified so that there is still someone in the child's life with whom she can develop a trusting relationship.

Lastly, the impact of sexual abuse on the child vary depending on her age and development. Sometimes, it may be helpful to assist the non-offending parent to realistically understand the impacts of the abuse on her child in light of her age and development. The non-offending parent may be so overwhelmed by the disclosure that she loses sight of the needs of her child. When the mother is able to understand her child's reactions and to relate with the child in ways that support her developmental needs, this helps to strengthen their mutual trust and lessen stress and conflicts. To illustrate, Yuen, a mother of a 4 year-old girl, was traumatized by the discovery that her little daughter was groomed and molested by an adolescent in a community centre. The little girl did not understand the meaning of the abuse. For her, it was some secret play the "big brother" had with her. Yuen, however, reacted hysterically and could not stop crying whenever she thought of the abuse. She had lots of self-blame and fears about the girl's future, thinking that her life would be ruined. The girl could not comprehend her mother's reactions, thinking that she probably had done something wrong to make her mother angry. Besides working with Yuen on her traumatic reactions and the meaning of the abuse to her, she was helped to see the cognitive development of her 4-year-old daughter, so that she could have realistic understanding of the potential impact of the abuse on her daughter. When Yuen was able to understand her daughter's needs and concerns in light of the latter's development and needs, she was less reactive and the girl's anxiety at home was lessened.

Family work with the child and the non-offending parent(s)

When both the child and the non-offending parent have clarified their confusions and dilemmas around issues of abuse and their relationship with one another in their individual sessions, they are invited to have joint sessions to talk further on issues of safety and trust, and in particular, how they can work together in daily life to strengthen their relationship. The therapist needs to discuss with both parties on what materials they want to bring from their individual sessions to the joint sessions. Such discussion is called Decision Dialogue (Sheinberg and Fraenkel 2001). It is important in the sense that both can participate in the decision on when to talk what, which is empowering to families who, having gone through the experience of sexual abuse, are often left with a sense of powerlessness and helplessness.

Back to Ling's story, Ling was informed separately beforehand by the therapist about what her mother wanted to say to her and she agreed. She was curious as to what those stories were about. In the session, Li told stories of her grandmother, her mother, and herself. Ling listened with curiosity and they all laughed together in listening to the mother's "love story". Li expressed that she had made a wrong decision in marriage because of blind loyalty to her parents. This was significant for Ling to hear personally from her mother who eventually chose to stand on her side (Li's courage to reclaim her belief echoed Ling's courage to disclose the sexual abuse by her father). Li then talked about her hope for Ling to find her happiness and true love in future, "I hope for you not to be blindly loyal to your parents but to search for your own happiness," she said to Ling. Ling was excited to learn the strength possessed by the women in her family, how this strength was passed down from generation to generation and how the strength had helped them overcome and surpass many difficulties. She concluded in the session that she would pursue happiness and strength in her life.

In summary, in the story of Li and Ling, the therapist chose not to confront the mother about her disbelief of abuse in the first place, but rather tried to understand what might be contributing to her dilemmas and struggles. The therapist then heard a story of love and the importance to find one's own happiness, as well as an alternative story of strength in mothering practices that had existed in generations. The therapist was thinking beyond the problem narrative of the mother's disbelief and blame and rediscovered in her preferred stories of strength and finding one's own happiness. This became a different platform in the joint session in which Li was able to support Ling and the two were able to connect emotionally. The mother could also make a moral choice. Both Li and Ling were no longer dominated by the story of shame around the abuse. The rediscovered stories and the values that they treasured helped to build up their preferred identities and their connections to one another. This made it possible for Ling to change her perception towards her mother. Li was no longer a primitive mother, but a mother committed to her family and children. Listening to her mother's story and the strength that the three generations of women possessed, Ling felt proud and connected with the women in her family line. In the individual sessions with Ling, she showed more capacity to understand her mother's conflicts and to let go of her anger towards her mother for not believing her in the first place. Ling became less irritable at home.

In another family's story, Wong, a widower with a son, re-married with Chun in his home village in China. Chun gave birth to a daughter and they eventually all immigrated to Hong Kong. Though the couple had established their lives in Hong Kong, they kept close connection with their families of origin in their home village. Chun was very conscious of her reputation as a stepmother in the village and whether her stepson, Wai, would accept her as if she were his own mother. In order not to be gossiped as a wicked stepmother, she took extra care of Wai and he enjoyed extra privileges at home, to the extent that sometimes the daughter felt jealous. So, when the daughter Fong, aged 12, suddenly disclosed to Chun that Wai, aged 15, had molested her several times, she was shocked with anger. The case was subsequently made known to the authorities. Wai admitted the molestation and was removed from home. Fong, apparently under a lot of pressure after the disclosure, attempted suicide and was hospitalized for a few days. After Fong had been discharged from hospital, she and her mother, Chun, were referred for therapy, but the father, Wong, refused to come. However, Chun was concerned of her husband who was depressed after Wai had been removed to a residential home. She was also worried how her husband's depressed mood and his missing of Wai would affect Fong. Wong would speak of killing himself whenever the couple quarreled. Chun felt burdened by her husband's verbal threats and the couple was irritable at home. In the individual sessions with Chun, the therapist worked with her the burden of the "stepmother legacy", her roles as a mother and a wife, the meaning of reputation in her home village, and her feeling of being betrayed by Wai. When she became more assured of her role as a mother, and was validated of the hurt she had deeply felt in Fong's victimization, she had more capacity to express her care and concern to Fong in a softer manner. The therapist discussed with her what issues she wished to bring up in the couple's session and to the session with Fong. She said that she would like to know whether her husband had recognized her contributions in the family, as well as to tell him that she was burdened by his repeated verbal threats of killing himself. She would also like to tell Fong that she too felt the hurt and she would protect her and make sure that no abuse would happen again. Under Chun's persuasion, her husband finally agreed to come in for a couple's session.

Wong, in his mid-forties, had a dark complexion and lines on his face, and had rough hands. His physical appearance told the therapist that he had worked hard in his life. The therapist joined him by having conversations with him on his work and how he had contributed to the family as a hard-working husband and father. He was also asked of his expectations and hopes for his children. Wong then told a story of how he had struggled in China and then in Hong Kong to establish his work and his family, and how he had earned and valued his reputation as an honest and responsible man, both in his village and at work. Being influenced by the traditional Chinese values about the different roles of men and women, and the importance of the firstborn son in a family, he worked hard as the sole breadwinner of the family, and he often favoured the elder son, Wai. At the same time, he also had expectations of Wai and hoped that he would bring pride and good reputation to the family, particularly back in his home village. Thus, it was a double blow for him to learn of the molestation and to face his son's subsequent removal from home. Preoccupied with both shame and fear of losing his son, Wong was depressed and irritable. At Chun's request to show more concern to Fong, Wong tried to approach Fong, but his irritable mood scared Fong, who thought that the father was angry with her and blaming her for her brother's removal from home. Unfortunately, in response to Fong's distancing, Wong felt further rejected and disrespected, resulting in more frustration and irritation. A cycle of negative interactions thus persisted.

With this understanding of how the abuse incident had affected the family members' relationships by locking them in a cycle of negative interactions, and with the knowledge of Wong's values of honesty and responsibility which he took pride in, the therapist first showed respect for the contribution he had made to his family, as well as acknowledged the expectations he had for his son and the attempts he had made to approach Fong. The idea of manhood and what constituted a responsible man in a family and society were then raised with Wong and Chun. Wong took pride in having treated his wife well and in having provided the family with a secure living. He spoke of what he believed a responsible man should be like, in which one of the qualities was to know how to respect women. When asked what he meant by respecting women, he replied, "Such as not to touch them indecently." "So, how would you help your son grow up to be a responsible man so that he knows how to respect women?" the therapist asked. This opened up a dialogue that changed the meaning of his son's removal from one of losing him to one of helping him to learn to be a responsible man through the programs and counselling offered by the social worker. It also helped Wong see the importance for his son to take responsibility for the abuse, if he was to learn to be a responsible man. With this changed perspective, both Wong and Chun were able to recognize each other's contribution in raising their children and establishing a family together. Through the conversations, the father's life story and identity were no longer dominated by a story of shame and loss, but were expanded to include a story of pride and responsibility. With this expanded perspective, he had more capacity to understand the impact of abuse on Fong and to show more patience of Fong's need for personal space at home. "Let me die!" was no longer heard in the family. Quarrels between the couple were much reduced.

Again, the work with Fong in individual sessions would not be the focus here. In general, she coped quite well in daily functioning. Her attempted suicide after the disclosure was a reaction to the parents' conflicts around the abuse, and the pressure and blame she experienced at her brother's removal. She had no prior history of self-harming behaviour. It was unlikely that Fong would harm herself again. However, Fong felt annoyed and intruded upon by her mother's frequent checking on her since her attempted suicide. In the joint session with Fong and Chun, Chun was helped to express her regret to her daughter for having blamed her for not telling the abuse earlier. Chun told Fong that she felt hurt too upon knowing what Wai had done and that she would do her best to protect Fong in future. With this reassurance, Fong then told her mother why she did not disclose the abuse earlier. She was worried that her parents would not believe her, as she perceived that they had favoured Wai over the years. She then let her mother know her need for personal space at home. With the help of the therapist, she told her mother the stress she had during the disclosure and she reassured her mother that she would not hurt herself again. All these issues had actually been discussed in the individual sessions with Fong prior to the joint session, and Fong had agreed to tell these to her mother in the joint session with the therapist's assistance. The mother and the daughter then had a discussion on what to do in their daily life so as to regain and rebuild their confidence towards one another. When the mother and the daughter were connected through their shared pain and reassurances of support rather than fear and blame, their perceptions of the relationship and their interactions changed. They were less irritated, fought less and had more understanding of each other.

Summary

In short, the primary goal of joint sessions with the child and the non-offending parent(s) is to strengthen their relationship and to rebuild trust between them, so that they can dissolve the difficulties brought by and heal from the negative effects of the sexual abuse. To achieve this, the therapist has to work on the blocks that hinder the non-offending parents' capacities to be empathic with the abused child. The non-offending parents' overwhelming emotions towards the abuse, their fears and worries, their dilemmas and conflicts, their life experiences, their beliefs that affect the ways they respond, and the values that they cherish despite the abuse, all need to be explored and addressed.

Family work with the child, the non-offending parent(s), and the offending family member

One goal of the relational approach is to clarify the child's confusion toward the offending parent / family member and to make safe the relationship, whether he will return to the family or not. Although there are personal and family variables that contribute to dysfunctional family interactions, the therapist has to stand on a clear moral position that the perpetrating family member has to take total responsibility for the abusive acts. Other family members, including the child, are not to be blamed for the abuse. The therapist has to be conscious of the exercise of power by the perpetrating family member, usually the father or the father figure, over the child and how other factors such as gender beliefs and family roles help to maintain the power distribution in the family.

As working with the offending family member is outside the scope of this chapter, we would state only the criteria that the offending family member has to meet before a joint session with the child and the non-offending parent is held. The first and foremost criterion is that the perpetrating family member takes *total* responsibility for the abuse. He makes no excuses, which sometimes can be subtle, for the abusive acts. An example of subtle excuses would be for a father[12] to say, "I'm sorry for what I did. I was abused as a child, and I think I was messed up. I would never do this to you again." For the apology, he can either apologize in the form of writing if he and the child cannot meet; or face to face with the child and the mother in an apology session if the child is ready to accept his apology. He has to learn to be empathic to the impact of abuse on the child and other family members. He also needs to be aware of how he has made use of his position in the family to exert his power in an abusive way. Furthermore, he has to commit himself to what he would do to ensure that he would not offend again.

Secondly, it is important that he does not pressure or induce the child to feel pity for him and thus to forgive him. The distinction between a self-centred apology and an other-centred apology is important (Jenkins, Joy and Hall 2002). When the father focuses on his own suffering or apologizes for a particular end result, even though he admits his abusive behaviour, he is still prioritizing his own interests and needs over the child's needs. In a self-centred apology, a father subtly puts pressure on the child and the partner to pity or forgive him, perhaps by saying how miserable or painful he has felt, for example, “I know I do not deserve to be forgiven, and I cannot forgive myself too. I would carry the pain for the rest of my life.” Another example of a self-centred apology would be a father who apologizes as a means to achieve reconciliation. “I am very sorry for having hurt you. I promise I will change myself and never do this again. I hope we will work together for a better family.” If the perpetrating family member truly owns up total responsibility, he will prioritize the child’s best interests over his, and there are no strings attached to his apology. He understands and accepts that his apology does not entitle him to any specific responses he desires to have from his family members.

In preparing for an apology session, the therapist has to make sure that the offending family member, the child, and the non-offending parent are all ready for the meeting; and that they are ready to talk about how to build safe relationships in the family. The child also participates in the decision whether to forgive or not and whether she wants such a session. The goal of an apology session is not for family reunion, but for the interests of the child. The therapist needs to be sensitive to the child’s voice on this issue, since usually children lack the negotiation power to assert their preference in the family. Sometimes, a child says yes for family reunion simply because she knows that her mother wants it, and she does not want to risk losing the mother’s love by opposing her wish.

Let us go back to the Wong’s family. After a year of living in a residential home, Wai asked to return home. The social worker was satisfied with his progress and suggested that the family could try temporary measures such as weekend home stay for Wai before implementing the reunion plan. Chun became anxious about Wai’s return. She found herself not trusting him. Separate sessions with Chun, Fong, and Wai were arranged to check on their perceptions and concerns about the home leave plan. In fact, both Chun and Fong were ready to forgive Wai if he genuinely was remorseful of his behaviour and showed evidence of change. Nonetheless, at the same time, they felt anxious in relating with him. Trust was the key issue at play. They agreed to meet Wai in a joint session. They were first briefed of the goal of the meeting and they participated in deciding which topics were to be raised in the meeting with Wai. In the individual session with Wai, though a bit tense initially, he acknowledged responsibility for the abuse and also how he had misused his role as an elder brother in molesting his sister. He was willing to apologize to his sister and mother for the abuse, and he was asked to think what he would do to change his behaviour and to build up a safe relationship with his sister.

After all these individual meetings, the parents, Wong and Chun, and their children, Wai and Fong, came together for the apology session. The therapist stated the goals of the session at the start and the parents were invited to tell how they perceived and felt about the abuse. Fong decided to keep quiet in this round. Wai was then invited to say his apology to his sister and his mother. Both Fung and Chun were attentive to what he said. They were then asked how they felt about the apology and what they wanted to say to Wai. Both were willing to accept Wai's apology. It was significant for them to hear from Wai that he took full responsibility for his act. Chun took this opportunity to restate her hurt and disappointment in the abuse. The father was also invited to state his position that he wanted Wai to learn to be a responsible man and that he would be serious in his stand. The safety plan was the next agenda to be discussed. Each was invited to tell their expectations, and also to comment on Wai's proposal on what he would do at home to show respect to Fong and to earn the family's trust. After this session, Wai did not come again. He returned home three months later and continued the supervision by social worker. The therapist met with Chun and Fong several more times to check on the progress at home. Chun shared that although there were some adjustment and embarrassment at the beginning, Wai kept his word on what he had committed to do, such as not staying alone with Fong and not going into her room. Chun was also more assertive in relating with Wai. Gradually, Fong was more relaxed at home and this relaxed Chun too. She also found that Wai was more outgoing than before and spent more time with his peers.

Summary

In cases where the offending family member denies the abuse or is imprisoned, or where the non-offending parent decides to separate from her partner, apology from the offending member is not likely. Under these circumstances, the therapist has to work with the child on how she perceives the offending family member's denial or justifications, how to separate herself from self-blame, as well as how she can regain justice and a positive sense of self with the support of other persons in her life.

From the above stories, it can be seen that each family and each person makes meaning of the experience of sexual abuse differently, and hence is impacted differently. The therapist needs to understand how beliefs in gender and family roles, family interactions, and the meanings constructed about the abuse influence the family's perceptions and responses to the sexual abuse. Bearing these in mind, the therapist engages the non-offending parent(s) to explore their dilemmas and clarify their confusions, invites them to expand their capacities to understand the child's feelings and needs, and facilitates them to make a moral choice. In addition, the therapist also has to work on changing any negative patterns of interactions among family members so as to restore a safe and nurturing family relationship for the child. Last but not the least, work with the offending family member is of salient importance in the safety and recovery of the child and the non-offending family members. Although this work is currently very difficult to be implemented because of limitations in the social and legal systems in the local context, wherever possible, the offending family member should be invited and engaged in therapy.

Group work

We have emphasized a family-based relational approach in our work with sexually abused children and their families. Still, group work has its place and relevance. Bringing children who are rejected by their families together in groups helps to break down their sense of isolation, disconnection and stigmatization. In the earlier sections, we have talked about the importance of fostering supportive and nurturing relationships for the sexually abused children with other significant figures if family members are not available. Groups are another valuable option here.

Setting up the group

In facilitating groups for sexually abused adolescents,[13] the same core ideas that are discussed in the earlier section apply. One central principle in the family-based relational approach is for therapists to interweave information among different therapy modalities (individual, family and group sessions) when working with sexually abused children/adolescents and their families. It is therefore preferable that the same therapists who see the adolescents individually act as therapists for the group. We find that it is also easier for the adolescents to speak up as they already have some familiarity with the therapists. It also seems to work best if the group members share common experience, such as being rejected and blamed by the family, being close in age with one another, and experiencing similar severity in the abuse. Where possible, it is helpful to recruit some group members who have already reclaimed some aspects of their lives from the effects of the abuse, so that they can share stories of hope and strength with those who are still in the turmoil and struggling with difficulties. In addition, ensuring certain degree of structure and predictability of the group helps the members to feel safe. Safety is fostered through regularity of time and place to meet, clear guidelines of conduct for group members, and similar structuring of each group meeting into components such as checking in, discussion of a particular theme, and closure.

Group content

Early on in the groups, the therapists collaborate with the group members to invite them to give opinions on what issues they would like to discuss. It is hoped that the group members can experience a greater sense of agency through participation in deciding the content, as well as the format of the groups.

Artwork as an adjunct Artwork can be a useful adjunct for discussion of the difficult subject of sexual abuse. In one group, the members found art activities like making collages to introduce themselves and to express their feelings and thoughts about the abuse in the early meetings helpful both as an icebreaker and also to lessen the initial anxiety. Sometimes artwork helps to instill a sense of cohesion and shared purpose in the group. One group came up with the idea of having a symbol of a Flying Heart to represent the primary group value of “Love, Hope and Freedom”. This group, with a member talented at needlework, made the Flying Heart to be displayed in every meeting. The therapists often make sure that an array of art materials is available for use in the group meetings. Group members are given the option of using artwork as an alternative medium of expression in addition to the use of language.

The use of food Food is another important element that the therapists include in every group meeting. Food is a symbol of nurturance and sharing. In the Chinese culture, families and friends enjoy the sharing of food to enhance the sense of mutuality and togetherness, whether on daily occasions or during special times. In our groups, the adolescents usually sit at a round table, sharing snacks while talking about the difficult topics. They also participate in deciding the snacks they would like to have. Sometimes, some group members brought food they made to share with the others. The therapists always take care to instill an atmosphere of care and mutuality in the group sessions when difficult topics are being brought up for conversations.

Inclusion of the larger context One important topic that is usually brought up for discussion in the groups is: how the larger context has made the group members’ experiences more difficult (the core idea of “social context in the life of problems”). The group members are invited to reflect and discuss how the negative societal responses and gender beliefs influence them to think negatively of themselves. Some examples of the negative social and gender beliefs that were discussed in the groups are: women are responsible for the sexual assault because of the way they behave and dress; or sexually abused girls are inferior or damaged. The group members are invited to discuss the effects of these beliefs on them, what positions they want to take, how they want to respond to these societal responses and beliefs, and whether they find these beliefs helpful to them.

Discussing the effects of abuse: the use of metaphors and thinking beyond the problem narratives The other topics often brought up for discussion in the groups are self-blame, guilt, shame, confusion, fear, anxiety, anger and self-harm, namely the many difficult effects of the abuse and of disclosure the group members struggle with. The therapists facilitate the groups to speak of the difficulties in an externalized way, as in Mei's story in the section, "Individual work with young children". Metaphors and symbols are used to represent the different topics for conversations. Some of the metaphors that we have used in the groups include: a dumping ground in which the members put down the burden of secrecy, a swamp in which the group talked about ways of getting free from the quicksand of self-blame, a dense forest in which the group found their ways out of confusion, a big hand that represented conversations about breaking free from the tight grip of guilt and shame, a candle that symbolized hope against fear, and a "wonderland" that represented the end stop where the group would find new skills and abilities and new preferred stories of strength. Externalizing the problems by speaking in metaphors puts a distance between the adolescents and the difficulties they are struggling with. In turn, this makes it easier for them to notice ways and steps that they have used or can use to overcome the problems.

It is important that the therapists think beyond the problem narratives and listen to the group members on a double level. The therapists not only listen to the group members' painful experience of the abuse, but also take note of how the group members have struggled and taken steps to stand up to the effects of sexual abuse. The therapists enquire the values, beliefs, hopes and commitments that have supported the adolescents in taking those steps to reclaim their lives from the effects of the sexual abuse. These values, beliefs, hopes and commitments speak to the adolescents' more preferred stories of strengths, resources and pride. Connecting the group members' lives through shared values, beliefs and hopes help to reduce their sense of isolation tremendously and enhance their sense of personal agency. For example, in one group, one member shared that she felt angry and being unfairly treated. When prompted, she reflected that the anger had to do with the belief that she had done nothing wrong (the idea of "thinking beyond problem narratives"). Another member resonated with this belief and shared her thoughts and experience. A third member also shared similar belief but talked about how hard it was sometimes to keep this belief because the whole family blamed her. The group was then asked how they still managed to sustain this belief despite so many pressures, why it was important to keep this belief, what difference this belief would make to their lives, and so on. As the conversations went back and forth, the belief that "one has done nothing wrong" became richly described, and evolved into a group story of strength. This is how the therapists facilitate the conversations to foster a sense of positive identity, hope and most importantly, connection in the group, so as to assist the members to overcome the distressful impacts of abuse.

Some more examples of the values, beliefs and hopes shared by the group members are: the belief of the importance of connections, the commitment in fairness, the belief to hang on even though things are tough, the hope to live their lives free from the effects of abuse one day, and the value of compassion and empathy arisen from their suffering. After these conversations, the group members gave the feedback that they felt stronger, freer, happier, less lonely, more hopeful and more confident that they would overcome the difficulties brought by the sexual abuse.

To reiterate a point made earlier, the therapists can interweave information from the group sessions to the individual or the family sessions, or vice versa, depending on the adolescent's needs, and with the adolescent's full knowledge. The different therapy modalities complement one another. Take the example of Sui whose story was shared in the section of Individual Work. Sui's skills and resources in dealing with the "voices" were brought back to the group in one group session (Sui was one of the group members). Members acknowledged Sui's cleverness in dealing with the voices, and shared how her expression of "it all came down to a matter of choices of how she wanted to attend to the voices" had inspired them to think along similar lines. This in turn contributed to a stronger sense of personal agency in Sui, as her life story was able to impact and bring changes to the lives of other members.

The importance of creating hope To instill a sense of hope, as aforementioned, it helps to have some group members who have already established some aspects of their life free from the effects of abuse to share their stories with those who are currently in struggles and turmoil. From our experience, we also find that the journey metaphor is useful in creating hope (McPhie and Chaffey, 1998; White, 2002). The group is likened to a journey. The members set off on a journey to explore different places (the discussion topics) and they all share a common hope that they will reach the "wonderland" where they will find new skills and knowledge about themselves, as well as strengths and resources that help them survive and surpass the negative effects of abuse. As a note of caution, we do not want to give the wrong impression that the process of traveling to this "wonderland" is easy and smooth, as our writing may sound. The process is full of setbacks and difficulties instead. For example, there was one group member who had to be hospitalized for self-harm while another group member, overwhelmed by shame and self-hatred, struggled tremendously in coming to the group, and almost dropped out. The journey metaphor makes it easier for the group members to notice the steps they have taken, however small, when they compare the place they are currently at to the place they start off initially. The steps they have taken become the foundations to open up conversations for more preferred stories of strengths and pride.

The use of rituals In group work, the therapists always make sure to include rituals to celebrate the steps taken by the members to get their life back from the negative effects of abuse, to honour their skills and strengths in overcoming difficulties, and to commemorate their new-found preferred identities. Rituals help to build up group solidarity and also help to consolidate and strengthen the preferred identities and stories. Sometimes, it is in the format of an award presentation ceremony (for example, an award may be presented to congratulate a member for her bravery in standing firm on her belief in fairness and in taking the witness stand in court), or a feast celebration. All members participate in deciding what they feel would be a meaningful ritual for them.

Last Words

In this chapter, we shared how we work with children and adolescents who have experienced sexual abuse in their families. The approach chosen is shaped by our values and beliefs, ideas adopted from different schools of thinking, and actual clinical experience. While this is not the only way to work with sexually abused children and their families, it works for us and guides us in navigating through the many complex challenges these families brought to us — their confusions, dilemmas, struggles to make moral and sensible choices, and the difficult repercussions of sexual abuse. When child sexual abuse is considered not only as a psychological trauma, but also as a social problem that exists in the larger social and cultural context, it invariably challenges the therapist to continually reflect and find better ways to help these families. By sharing our work, we hope to expand and enrich both the ideas and ways of working with sexually abused children and families in the local setting.

Notes

1. Each author has equal contribution to this chapter. We are grateful to Peter Fraenkel, for his valuable comments and arduous editing work on the manuscript, as well as our colleague Linda Chew for her feedbacks and help in proof reading. We also wish to thank all the children and families for sharing their most personal stories with us and giving us the privilege to walk with them this journey of reclaiming their lives from sexual abuse. We would like to dedicate this chapter in the fond memory of Michael White (1948–2008), our teacher and friend. His thoughts and passion in narrative practice have inspired and influenced our work with children and families struggling with the problem of sexual abuse.
2. By psychological effects of abuse, we do not mean only cognitive, emotional and behavioural disturbances or individual symptomatology. More importantly, abuse impacts on how children experience their most significant interpersonal relationships, and their sense of self.
3. Familial child sexual abuse refers to sexual abuse by members in the immediate family or in the extended family.
4. In this chapter, for the sake of convenience, the pronoun “she” is used to refer to the sexually abused child, both males and females, in view of the higher frequency of females being sexually abused than males.

5. Similarly, for simplicity sake, the pronouns “she” and “he” are used to refer to the non-offending parent and the offending family member respectively, because in most cases of familial child sexual abuse, the offending family member is usually a male. When the offending person is a parent, it is usually someone in the father role, while the non-offending parent is usually the mother.
6. In modern psychology, our training in making assessments and giving diagnoses would easily lead us to see problems as individual deficits or internal disorders, but ignore and forget the often important and ever-present influence of the broader context on individuals and families.
7. Readers interested in exploring further the idea and application of collaboration in family therapy may consult the book edited by Harlene Anderson and Diane Gehart (2006) “Collaborative Therapy: Relationships and Conversations That Make a Difference”.
8. For confidentiality reason, all identifying information of the families is modified and aliases are used.
9. For simplicity, we would take the scenario of a situation of incest, where the sexual abuse was perpetrated by the father against the daughter.
10. Work with persons who perpetrate sexual abuse in families can include individual, group and family work. This is also a specialized area of work that would warrant a separate chapter. The current chapter will not cover this area of work, but does not mean that work with persons who abuse is not important. Quite the contrary, this area of work is extremely crucial. When an offending family member is willing to be fully accountable for the abuse he has perpetrated, this can sometimes be immensely helpful to the abused child and to the non-offending parent’s healing and recovery.
11. The externalizing way of talking about problems is a skill in narrative therapy. Readers who are interested can read more about the skill of externalizing conversations in Alice Morgan’s book “What is Narrative Therapy” (2000), p.17-32, and Michael White’s book “Maps of Narrative Practice” (2007), Ch.1, p.9-60.
12. For simplicity sake, we would give examples of the father being the offending family member.
13. Since we have mostly worked with adolescent girls in groups, we would be talking about groups for adolescents.

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8

Wounding and Being Wounded:
Vulnerabilities, Emotional Injuries and Victimization of the Male Batterers — A Qualitative, Collective Case Study

Chung-ming Chan

Introduction

Towards the end of last century, our society has slowly awakened to the impact of the partner violence problem. A Central Information System was set up in 1998 and has since then recorded a continuing increase of newly reported partner violence cases: 1,009 in 1998, 3,034 in 2002, 1,665 in the first six months of 2006, with the majority of victims being women (96% in 1998; 92% in 2002; 85.9% for the first six months of 2006). The society has been particularly shaken up by the occasional homicide-suicide family tragedies. In the Tsz Wan Shan incident in January 2002, a 49-year-old man, several days after losing a custody battle, killed his two young children, seriously injured a teenage daughter and then hanged himself. Two years later in April 2004, a 45-year-old man, before committing suicide, killed his wife and his twin daughters who were only six years old. The most recent incident occurred in November 2006 in which a 43-year-old man killed his divorced wife, a 20-year-old step-daughter and a 9-year-old daughter.

In parallel to society's increasing concern, tremendous effort has been made by government and non-government organizations in developing multifarious strategies and services to combat the serious problem (Social Welfare Department [SWD] 2002, 2003). These strategies include: utilizing large-scale publicity and community education in order to promote public awareness of the problem and the importance of seeking early assistance; setting up specialized service units to deal with partner violence cases; improving the sensitivity and handling skills of front-line professionals (such as teachers, police, etc.) in their everyday management of partner violence cases; establishing additional battered women refuges, crisis centres and hotline services; and pioneering group intervention services for batterers and victims.

Since the year 2000, I have been actively involved in partner violence services, working with individual cases and later collaborating with social worker colleagues in developing treatment groups for male batterers as well as women victims. In the meantime, I have also been researching, partly through my everyday work and partly through my doctoral study, for an understanding of male battering, and this chapter represents part of this research effort. In the following, I will give a brief review of the current literature on understanding male battering, present the rationale for my research on the different "faces" of male batterers and the research methodology, report in detail the findings on the "vulnerable face" of these men, and discuss the implications of the findings for research and intervention.

Literature review

Differentiation of the batterers sample

The literature on partner violence has a general consensus on the heterogeneity of perpetrators of partner violence (Aldarondo 1998; Guille 2004) and there have been calls for specific explanation of different types of violence (Clarke and Cornish 1985; Gelles and Straus 1979; Bograd 1999). However, Greene and Bargo (2002) state that partner violence literature rely on two different samples and give rise to disparate findings: the community samples that find low levels of partner violence, and the clinical samples that are drawn from courts, hospitals and shelters with severe violence cases mainly perpetrated by men.

In an attempt to differentiate the heterogeneous batterers population, Holtzworth-Munroe and Stuart (1994) have identified three dimensions which are found consistently to differentiate among subtypes of batterers: severity of violence, generality of violence, and psychological functioning. On the basis of these dimensions, three main types of male batterers are suggested, namely, (1) *family-only,* (2) *dysphoric/borderline,* and (3) *generally violent/antisocial.* The "family-only" batterers, estimated to constitute 50% of batterers, engage in the least severe violence and show little evidence of psychopathology or personality disorder. The "dysphoric/borderline" batterers, estimated to constitute 25% of the batterer samples, engage in moderate to severe wife abuse and in violence outside the family; they are involved in other criminal behaviour and likely to have borderline and schizoid personality features. Finally, "generally violent/antisocial" batterers are estimated to constitute the remaining 25% of batterers who engage in moderate to severe violence to their partners as well as outside their family; they have extensive criminal records and are likely to have substance abuse problems, antisocial personality, or psychopathology. The Holzworth-Munroe and Stuart's batterer typology has been supported in several empirical studies (Hamberger et al. 1996; Holtzworth-Munroe et al. 2000; Tweed and Dutton 1998; Waltz et al. 2000).

The need for a multi-dimensional explanation

There is also apparent consensus in the literature that partner violence is a very complex problem which indicates the need for a multidimensional explanation (Barnett et al. 1997; Dutton 1988; Fagan and Browne 1994; Gelles and Straus 1979; Goldner 1999). Dutton (1981, 1985, 1988) has proposed a theoretical structure called the "nested ecological theory" to integrate the social and psychological characteristics of batterers. According to the theory, there are four levels of analysis for the characteristics of batterers, namely, the *macrosystem,* which refers to broad cultural values and belief systems such as patriarchal values; the *exosystem,* which refers to the formal and informal social structures (such as job stress, low income, unemployment, and the presence or absence of social support systems) imposed on the immediate settings of an individual and thereby influence his behaviour; the *microsystem,* the immediate context in which wife assault takes place and factors such as the couple's communication and interaction pattern, their conflict issues, their power differential, and the process of assault; and *ontogenetic factors,* which refer to the individual's developmental experiences with violence that shape his responses to the three-level social context. Goldner (1999) has also advocated a stance of *multiplicity*, a "both-and" position in approaching partner violence cases. She calls for a "moral and psychological discourse" and suggests that explanation of partner violence has to draw on multiple theoretical perspectives.

Different points of view in the literature

According to my review, the literature on partner violence has been influenced by a number of views in understanding male battering. The "feminist point of view" emphasizes the role of patriarchal values in the men's justification of using violence to their partners (Dobash and Dobash 1979; Bograd 1999; Yllo 1988, 1993). The "internal experiences point of view" examines the men's expectations and frustrations in intimate relationships; violence is believed to be used by the men as an attempt to protect themselves from being overwhelmed by emotions arising from the frustrations (Goldner et al. 1990; Chan 2000). The "interpersonal point of view" studies the men's violence in the context of relationship conflicts and power struggle between the partners (Chan 1996). Finally, the "interventionist point of view" focuses on combating the men's violence and proposes various strategies to change the men (for example, Emerge 2000; Pence and Paymar 1993; Geffner and Mantooth, 2000).

While each of these points of view has its own merits, it tends to present only one "face" of the male batterers and is often based on a particular ideology or theoretical perspective. My clinical work with the batterer clientele suggests that the significance of each "face" as depicted by the different points of view may vary over time and from one man to another. More importantly, in working with partner violence cases in which the men present themselves in totality with their different "faces", there is a complex interplay of the different "faces" for each man, which gives rise to a different persona as that provided by a separate analysis of the individual "faces". It follows that it is not only theoretically insufficient but also clinically impractical to look at the male batterers with only one point of view.

The Research

This research which was part of my doctoral study (Chan 2005) was a qualitative, collective case study. It aimed at exploring (1) how each of the "faces" as described by the different points of view in the literature manifests itself in the men of a local sample; and (2) how the different "faces" interplay with each other in the men. Basing on the four different points of view in the literature, four different "faces" of the men, namely, their "chauvinistic face", their "vulnerable face", their "face in marital conflicts", and their "face in response to external intervention", and their interplay were examined. In this chapter, I will focus on the discussion of the men's "vulnerable face" and its interplay with their "chauvinistic face".

Sample

This research was located in a government social welfare organization where I had been working and since 2002 running a batterer treatment group for men. The group was targeted at a batch of "family-only" male batterers (Holtzworth-Munroe et al. 1994, 2000) who wished to maintain the marriage but were demanded by their partners to control their violence. It consisted of two stages: the first stage was a seven-session psycho-education which aimed at educating the batterers on the nature and consequences of partner violence and motivating them to take up the responsibility for change; the second stage consisted of 14 sessions and aimed at a more in-depth review and management of the men's individual and marital problems underlying their violent behaviour. The men recruited for this research was a convenience sample drawn from two batches of this batterer treatment group. Eight participants and their partners consented to join the study.

Table 8.1 presents a summary of the background characteristics for the eight cases researched in this study. The men were on average seven years older than their partners. Almost all of the men and their partners had emigrated from mainland China, with the men staying here much longer than their partners. The majority of the men and their partners received only primary or junior secondary education. At the time of the study, half of the cases lived on public assistance. The average duration of their present marriage was 13 years.

Table 8.1 Summary of the background characteristics for the men and their partners

	Men (N = 8)	**Partner (N = 8)**
Average age	44 (range: 27–63)	37 (range: 27–48)
Place of birth	HK – 2 Mainland – 6	HK – 1 Indonesia – 1 Mainland – 6
Average length of stay in HK	20 years[1]	6.7 years[2]
Education	Primary – 3 Junior secondary – 2 Upper secondary – 3	Primary or below – 3 Junior secondary – 3 Post secondary – 2
Employment	Employed – 4 Unemployed – 4	Employed – 4 Unemployed – 4
Family income	4 on public assistance	
Average duration of present marriage/relationship	13 years (range: 6–21 years)	
No. of children and age	Average number: 2 (range: 0–3) Average age: 11 years (range: 5–21)	

Notes: (1) Excluding two men who were born in Hong Kong (HK) and one man who had come to HK since young. (2) Excluding the woman who was born in HK.

Sources of data

Data for this study were drawn from sessions of the batterer treatment group which provided a platform for the men to address their violent behaviour and relationship problems. In addition, the men and their partners were interviewed individually with a view to acquiring a more in-depth understanding of their personal history and marriage development, their past experiences and marriage expectations, the development of marriage conflicts, the outbreak of violence, and their attempts to resolve the relationship conflicts. All the group sessions of the batterer treatment group and the individual interviews were taped and then transcribed for data analysis.

Data analysis

The eight cases were studied one by one. Each individual "face" was first examined and then interplay of the four "faces" was analyzed in the context of the man's individual and relationship development. Two forms of triangulation were in order in this research. First of all, analysis of the four "faces" of the man was based on three sets of transcripts collected in this research. Secondly, a female peer clinical psychologist served as a peer researcher and performed an independent analysis of the data; her views were consulted throughout the data analysis process.

The men's violence pattern

The focus here was on the men's physical violence. In this research sample, the men's use of violence was restricted to their family only. For one man, the violence used was infrequent and mild in nature. For five men, violence was used frequently at times of confrontation with their partners, and the violence used was of moderate severity — slapping, punching, kicking, hitting with objects, throwing things, and so on. There were two men whose violence involved death threat or physical injuries to their partners.

Vulnerabilities of the Men

The men's social-historical context

In the last two decades, our city has undergone tremendous changes in its economic, social and political structures. The changes were partly due to China's economic reform and open-door policy since 1978, and partly due to the return of Hong Kong to the sovereignty of China. During this period, there was an influx of immigrants from the Mainland who were looking for a better life in Hong Kong. Meanwhile, the economic systems of Hong Kong and cities of the Guangdong province (starting with Shenzhen) were gradually merging together.

The majority of the men in this research sample were among this influx of Mainland immigrants and they carried with them many wounds from their rough life in the past, and these wounds could be due to the political movements and financial hardship of their time, and/or the miserable developmental experiences in their birth family. They came to Hong Kong with a dream for a better life which was partly embodied in their wish for a family of their own, a value that was well cherished by them. These men were not very well-educated but they had worked hard to earn a living in Hong Kong. For those men who were brought up in Hong Kong, who may have enjoyed a better political and financial environment than their Mainland counterparts, their developmental experiences were no better off. They too carried their wounds from their past into their adulthood and looked for their healing in the family.

The mobility between Hong Kong and the Mainland has also facilitated the intermarriages between Hong Kong men (who were immigrants or otherwise) and Mainland women. These intermarriages have also been fostered by the men's difficulties or reluctance in finding partners in the city and the women's expectation to seek a better life in Hong Kong, an expectation that was somehow shared by the men or their parents in the past. These men and women were therefore joined by their wish for a family and their idealistic expectation to have a way out and improve their living standards.

A typical marriage between a Hong Kong man and a Mainland woman in this sample was a blitz union between the partners who were introduced to each other and then got married within days or weeks. There was no dating or courtship, not to mention any romantic love, between them. After their marriage, they lived separately, with the man working in Hong Kong and the woman looking after the children in the Mainland. They were then united in Hong Kong after some three to ten years after their marriage.

However, in spite of their union, they were yet to be united in many other ways — their daily routines including their financial management and family roles differentiation, their own relationship and father-child relationships, their culture, and so on. Indeed, these men and women have a huge variation in their cultural or ethnic background. They had different family origins — Hong Kong, different parts of Guangdong province, provinces outside Guangdong, and even places outside the country such as Indonesia. Such a difference represented, among other things, the men's variation in their male-dominated kinship system and patriarchal values which are still prevalent in many rural parts of the Mainland, the women's attachment with their own kin, and their exposure and openness to Hong Kong's relatively modern values in gender equality and social justice. At a micro-level, the difference also had an effect on how the men and women manage their personal and family problems in their everyday life.

At the same time, contrary to their wish for a better life in Hong Kong, the city had in the late 1990s suffered a serious blow to her economy which resulted in an economic downturn of the society, the unstable or loss of employment for many men, the financial crisis for their family, the impact on the men's traditional breadwinner status, and the employment of the women and their financial autonomy in the family. Moreover, in the same period, there was an increasing awareness of partner violence problem in Hong Kong and the society had been finding various ways to combat this social problem — public education, protection and support services for the battered women, social control especially in terms of police intervention, and counselling services for the men, and so on.

In other words, the men and in fact their intimate partners as well have been bombarded and hard hit by many changes in terms of their personal life, family development and changes in the larger systems in the society. They have tremendous adjustments to make in finding their personal and family development.

TIN's story

To examine the men's vulnerable face, I had in this research proposed to identify their expectations (or illusions) towards their own partner, significant developmental experiences conducive to these relationship expectations, frustrations encountered in meeting these expectations, life or family events that may trigger or aggravate their frustrations, their emotional reactions and management in face of these frustrations. To illustrate the men's vulnerable face, one man's story is presented in the following.

At a young age of seven, TIN was taken to Hong Kong by his mother who left his father because of his extra-marital affairs. Owing to his mother's poor health and financial hardship, TIN was sent to study in a boarding school. He equated this boarding school to an orphanage; nobody visited him and he was not allowed to leave the orphanage even during holidays.

> Since I was brought up in an orphanage, I had experienced a lot. I have never seen my own father and for my mother, she did not have the ability to take care of me and she sent me to an orphanage. In those days I had to strive for survival in the orphanage and experienced life in this human world. Other schoolmates had visits from their relatives during holidays, but I had to go without any of it.
>
> 因為我自己喺孤兒院長大，所以有好多都感受到，咁自己嘅家庭，老豆點嘅樣自己都唔清楚，到阿媽，阿媽無能力養我，所以放喺孤兒院養大。孤兒院長大，到頭來自己求存囉，果個年代，領略到人世間嘅嘢，人地放假其他院友有親人探望，自己都咁過。(Chan 2005, p. 67)

Moreover, TIN had been tormented by psoriasis since his childhood and he felt being looked down upon by others. Although the disease caused a rash that did not itch, at its worst state reddish spots spread all over his body and he had to wear long-sleeved clothes in order to hide the spots. He was told by the doctor that the rash was like a wave and would fluctuate with his mood. This rash problem together with the fact that he was not a rich man had been an obstacle in his marriage. He was jilted by one nurse girlfriend and his first marriage with another girl ended in divorce because of some sexual problems arising from the effects from the drug he took for psoriasis.

> The rash disease had a serious impact on me. I was not at all clear what happened in court when the Christian girl divorced me. I was later told by the social worker that she was discontented with me and she had strong evidence against me. She knew I had psoriasis when we got married. Because of the drug's effects and also because I had to work, I had little interest in sex. I had one girlfriend when I worked at sea; she was a nurse. She left me because her family said I had no money. I met this Christian girl after separating with her.
>
> 係，果陣時因為有病影響得好犀利，同基督教徒離咗婚，當其時法官判我因乜事離婚，自己都攪唔清，後來社工話俾我知 · 因某方面佢唔滿意我，佢有好強烈嘅証據，咁就可以離咗婚……佢知我有牛皮癬而結婚，因我食咗 d 藥，同埋做嘢，又對男女關係唔係好注重……我行船，佢做護士，佢屋企人話我窮，分開咗後來識得呢個基督徒女仔。(Chan 2005, pp. 125–129)

Just like everybody else, TIN had wanted to get married and have a wife and children. But because of his miserable family deprivation and marriage failures in the past, he had developed a reparative and heightened expectation for his family, and this expectation could be identified throughout his narratives. In his concept, family apparently provided him food, refuge, company, care, and esteem; it was reparation of what he suffered or lost in the past; and he would do everything to maintain his family.

> My wife and two daughters are in the centre of my life. I am an orphan and don't have any relatives, so there is nobody else besides them.
>
> 我老婆同兩個女放在中間，因我係孤兒，沒有親人，所以細圈外沒有人。(Chan 2005, p. 253)

> I am one who is very much attached to family and won't go anywhere. I don't know how to play mahjong or socialize with others … If I separate with her, I don't know how to cook, so I will hold on. Just like what the social worker said, you have a refuge, but you won't have any roof over your head after getting a divorce. I was brought up in the orphanage and I understand it from my experience. My tolerance is all for maintaining a family.
>
> 我依個人好鍾意家庭，唔會四處走，我連麻雀都唔識，唔識得應酬……如果分開咗之後，我唔識煮飯，唔識剩，我都忍住。好似姑娘講，你仲有個竇，依句說話好簡單，離咗婚之後，無咗遮頭。我喺孤兒院長大，自己經歷過知道，我咁辛苦都想有個家。(Chan 2005, pp. 152, 168)

> I very much wish to have a family, and I don’t want to live a life like this — even though me and my wife argue a lot in these days, I will still tolerate her. I feel good with a family, that is, like everybody else, I have marriage, wife and children.
>
> 我好希望有一個家庭，有家庭我又唔想行啲咁嘅路，好似而家咁我同佢嘈到咁樣我都會忍住忍住……即係如果有家庭就覺得好好囉……即係……人都要有婚姻有老婆有兒女架啦。(Chan 2005, pp. 92–94, 96)

At the age of 40 and through the introduction of a colleague, TIN started seeing his present wife YIN in the Mainland. YIN belonged to the Hakka clan and grew up in a remote village of Guangdong province. She came from an intact and close-knit family and she was the eldest child with three younger brothers. When YIN was 27, her whole family moved to Shenzhen. Her wish was to shake off the stereotype of being from a small village and move to Hong Kong.

While TIN readily accepted YIN because of her good educational background and quiet character, YIN, who was tall and had a slim build, was not that attracted to TIN because of his small build. Nevertheless, the couple continued to meet, once a week for a few hours, and their relationship then was uneventful. Not long after their courtship, TIN won four million dollars in the Mark Six lottery. In fact, in the following years, TIN had won hundreds of thousands of dollars several times in horse betting. In his prime, he owned several properties, some in the Mainland and some in Hong Kong.

The fortune turned TIN’s life around. As soon as he won the Mark Six, TIN quit his job, went back to Shenzhen and married YIN. The couple later had two daughters together. TIN built a four-storey house and brought YIN’s whole family to live with them. He spent all his time on the house, turning it into a most luxurious home in the region. In the first few years of the marriage, TIN had the happiest time of his life.

TIN had wished for a close and loving relationship with YIN. However, contrary to his wish, he was soon greatly frustrated by YIN’s close association with her maiden family and clansmen and he felt very much an outsider to the family established by himself.

> I’ve been hoping that she can treat me better. I will be very happy and contented if she can treat me like her Hakka relatives. I had pleaded to her not to treat me like that, asked her to be nice and gentle to me. I even said, just like men visiting prostitutes, you can just pretend it and let me have happiness for a few hours. At least I was happy for once. I asked her not to treat me like that; I married you not to argue with you all the time. But she didn’t make any changes.

> 我都係希望佢好啲對我囉，起碼對我好似對佢啲客家親友咁我已經好安樂，開心，好滿足架喇。我話，你唔好咁樣啦，你對我好啲啦,溫柔啲啦,甚至講到好難聽呀，我話好似人地果啲男人去叫雞，你地呃我，呃我幾個鐘頭開開心心，咁我都開心過丫……你唔好咁樣嚟對我丫……我唔係娶個老婆返嚟嘈交咁過日子架嘛，咁樣講到明佢都係咁。(Chan 2005, pp. 124, 208)

TIN also felt betrayed by his in-laws for their ungrateful response for the amount of money he had spent on them. He had thought of divorce but decided to stay on for the sake of his daughters as he did not want to see his orphan childhood repeat itself with them. Feeling hopeless in the marital relationship, TIN relegated his hope onto the girls' development and indulged himself in gambling. The family later emigrated to Hong Kong and TIN's frustration was exacerbated by his gradual and total loss of fortune and the delinquent development of his elder daughter. In struggling to save the elder daughter, he felt betrayed by his wife again as they could not agree on how to supervise the girl.

When faced with all the frustrations, TIN was apparently losing control and felt as if he would lose the family again. He had experienced a number of negative emotions. In his narratives, he had used a variety of words in expressing these emotions. Besides anger and resentment (嬲、好嬲、火), he had mentioned "no hope" (無希望、無哂希望、無辦法), "bad temper" (脾氣差), "bad mood" (情緒差), "emotional" (情緒激動), "sorrowful" (哭、傷心失望、悲傷、傷心流淚、好傷心), "painful" (痛苦), "fearful" (驚), "worried" (擔心), "jealous" (妒忌), "hateful" (憎恨、想殺咗佢), and "lonely" (孤單). And these emotions seemed to be jumbled together especially when his miserable experiences were invoked by his frustrations. Without proper ventilation and management, these emotions apparently fueled his temper outbursts and controlling behaviour in dealing with the frustrations in the family.

> My temper is not so bad that I would scold others all the time. I was brought up in the orphanage. Of course I wish to have a family. It's not been easy to go back [to the Mainland] and get married there, giving birth to two daughters and stay there for eight years. Then we came down here with the permit. Is it possible that I would destroy the family? It's due to the influence of life stress. She had to work for over ten hours. When she was off to work, nobody supervised the daughters. The elder daughter, once promoted to primary six, got acquainted with some juvenile delinquents … I have been arguing with my wife for many years … This May the elder daughter ran away. I feel hopeless now — arguing everyday for over ten years … I had lost money and of course I had to take the risk, but only losing all the money bit by bit … Money is the most important reason me and my wife fight, and I have lost all that money … (bursting into

> tears). This is it, it has always been like that; so there are many factors leading to this. They [other group participants] slept separately from their wife for one year; my wife and I have been sleeping separately for eight years … Can any other family go on like this? (becoming more emotional) … I have been tolerating and said nothing. My elder daughter ran away for almost six months and I had to quit my job to keep an eye on her. My wife had promised me but later did not keep her end of the agreement … Now she has left with the daughters (two group participants handed him the tissue) ... Now we are in a very dangerous position, going to disintegrate in any minute; four persons go four different ways — the daughters go their own way, I go my way, my wife goes her way … I've lost the money, can't get it back, owe the bank money, and will declare bankruptcy by June 24, now waiting for it. Again and again I have no way to regain the wealth, so we argue a lot. Who knew it was going to explode when the daughter's problem surfaced?
>
> 我脾氣差唔喺成日鬧人，我自己在孤兒院長大，我經歷人生……緊喺希望有個家，咁難得走上去結婚，生咗兩個女落咗嚟，喺上面八年，八年落咗嚟，攪埋証，有無可能將個家攪散晒，所以生活壓力有影响。佢又喺要做十幾個鐘頭，佢返咗工，啲女無皇管，大女一到六年班，識咗啲邊緣少年……咿家五月份嗰女又走咗去，我覺得無晒希望，又嘈天巴閉，十幾年婚姻嘈嘈嘈……我錢又輸咗，緊喺要博啦，陰吓陰吓，又陰埋……我同老婆嘈最大因素就因為錢，咁多錢無晒……（開始哭）咁就喺咁，一直都喺咁，所以好多因素攪到咁。佢哋一年喺咁，其實我八年都喺咁分床……邊個家庭可以喺咁（激動哭）……所以我唔喺好想提嗰D嘢……我忍氣吞聲咁講，大嗰個女走咗差不多半年，攪到我哋做緊工都唔可以做，要睇住個女。佢應承我，反口，結果佢帶住兩個女走咗……我唔想再講落去（送上紙巾），咿家我哋喺好危險邊緣，隨時分散，四個人四條路，女有女走，我有我走，老婆走……輸咗錢，攞唔返，又欠銀行錢……六月廿四號，宣佈破產，現在等緊，一次一次無辦法翻身……咁味成日嘈，點知嗰女一出事，就爆發出嚟……(Chan 2005, pp. 179–193)

The men's longing for family, miserable past experiences and "blitz" marriages

TIN's case illustrated one phenomenon that was clearly evident in this research, namely, the men's longing to establish their own family. In view of the decreasing number of marriages (42,568 marriages or 6.9 per 1000 population in 1991; 32,825 marriages or 4.8 per 1000 population in 2001),[1] the rapidly increasing number of divorces (6295 divorce decrees in 1991; 13,425 divorce decrees in 2001),[2] the changing family structures (from extended to small nuclear family), the diverse family types (single-parent families, remarriage, cohabitation), and the impact of feminist, marriage and gay movements in the Hong Kong society, there has been debate regarding society's culture and values for marriage and family (Young 2005; Lam et al. 2005). However, the male batterers in this research sample clearly subscribed to a family culture in the sense that they had been striving to find their family, although the subjective meaning of family may vary from one man to another.

In the majority of the cases, the men's longing for family could be traced to some miserable personal and family experiences in their past, which had fostered in them a heightened and reparative wish to find their own family. In TIN's case, he had endured a lonely childhood, rejected by others because of his psoriasis, and a failed marriage in the past. In KEN's case, during his childhood he had been severely abused by his stepfather and frequently bullied by schoolmates of Triad backgrounds; when he entered adolescence, he went through a long and lonely struggle to wean himself from the habit of seeking sexual gratification by groping girls while in crowded places. For another man LIU, he came from a poor family in a Mainland village, which was labelled as having a "bad element" — his father being a veteran from the Kuomintang. His family was victimized and LIU used to be bullied and hit by others, and his arm was once broken in a fight. It was not until 1979 that his family was given redress and at age 32 he finally had the chance of finding his first employment and first partner.

The eight men in this research sample had worked hard to make their living in Hong Kong and had maintained stable employment. At the same time, in spite of their limitations, they found marriage one way or the other, with a significant proportion having their "blitz" marriage with a girl from the Mainland or otherwise. This marriage pattern of the present research sample is in line with the trend of intermarriages between Hong Kong men and Mainland women (15,776 and 18,380 marriages with brides from the Mainland in 1986 and 2001 respectively).[3]

The men's relationship expectations

From the outset, the men's endeavours to establish their own families was an attempt to fulfill their reparative wish. But on a deeper level, they were apparently hoping that the intimate relationship could provide a healing to their emotional wounds and suffering that they endured in the past. For example, TIN was expecting from his wife an exclusive relationship in contrast to his childhood loneliness and rejection; KEN was expecting his girlfriend to provide him with a kind of unconditional acceptance and support in contrast to the childhood abuse and social judgment for his offending behaviour in his adolescence and early adulthood; and LIU was expecting from his wife intimacy and care to compensate for his prolonged victimization by the political movement. In other words, the men were seeking closeness, acceptance and recognition, care and support from their partners.

In the Western literature, Goldner and her associates (1990) based their account of the male batterers on the premise of "romantic love" between men and their partners. Similarly, local literature has suggested that our society has established the ideal of "companionship marriage" as the norm for marriage and that young couples are expecting the sharing of love, care, mutual help, support, encouragement and companionship in intimate relationships (Yeung and Kwong 1998; Young 2005; Lam et al. 2005). While these ideals for love and mutuality in the relationship were alluded to by the men in this research sample when they were asked about their marriage expectations in the treatment group or individual interview, the men's narratives however suggested an alternative picture. In my view, the blitz union for some of these men and their emotional needs to heal their wounds and sufferings defy the account of using "romantic love" or "companionship marriage" as the norm or model to explain the relationship expectations of them. The romance and mutuality suggested in such accounts are to a large extent compromised by the functional union of these men with their partners and their internal quest for healing of their emotional wound and suffering. Their "romance" lies more with their unilateral, idealistic wish for "family" rather than in the couple's relationship, and there is certainly little ground for "love" or "companionship" in their rushed, functional union. Instead of romantic love, the idea of "family" appears to be the core value of their relationship development; and instead of mutual care and support, their unmet emotional needs could, at least in the early stage, dominate in the partner relationship.

The men's frustrations: Life events, family problems and frustrations with their partner

Although they managed to find their marriage through a "blitz" union or otherwise, these men had endured a great deal of frustrations in their subsequent family development, and there were three main sources of their frustrations. First of all, they were in the past five years impacted by various life events or stresses such as serious health deterioration, unstable jobs or loss of employment owing to their health deterioration or economic downturn, financial loss due to gambling or business failures, death of close family members, being arrested and put on trial, and so on.

Secondly, as with all other families, these men had encountered frustrations in managing the family finances, child behavioural problems, and in-law conflicts. Half of the men received or were still receiving public assistance; all of them (including TIN) were in the past five years under a great deal of financial stress because of their unstable jobs or loss of employment. In terms of child supervision, three of the men had problems in supervising their children who warranted their special attention; in TIN's case, his two adolescent daughters were on the verge of delinquency. In terms of in-law conflicts, five of the men (including TIN) reported having conflicts, either between them and their partner's parents or between their own parents and their partner.

Finally, the men were greatly frustrated by the relationship with their partners. It should be noted that their frustrations were not so much directed towards the partner's household and childcare responsibilities, although many of them did have constant arguments with their respective partners in the latter area. Instead, they were frustrated by the way their partners related to them especially when they were faced with their life events and family problems. In other words, they were frustrated because their partners had violated their expectations of her role in the intimate relationship. In TIN's case, he felt being treated as an outsider by his wife. Moreover, some men were seriously wounded by their own partner's provocative response at a time when they were agonized by some personal or family crises: for KEN, his girlfriend used to threaten separation when he was awaiting trial for his sexual offences; for TANG, his wife had used an allegedly bogus extramarital affair to avenge her suffering in the relationship; and for TUNG, his wife refused to attend the funeral of his ninety-year-old mother, thus avenging her hurt at his refusal to attend her father's funeral many years ago.

The men's vulnerabilities, emotional frustrations and attachment injuries

The many frustrations were apparently an assault both on the men's sense of identity and in particular on their reparative wish to fulfill their unmet emotional needs in the intimate relationship. When faced with the many frustrations in their family life, they were confronted with a multitude of emotions which could be intense and overwhelming: sadness, loneliness, fear, anxiety, resentment, dissatisfaction, hopelessness, loss of control, being attacked or wronged, being trapped, being betrayed, being threatened, being neglected, being shamed or humiliated, being rejected, and so on. For some of them such as TIN, they would also experience a dreadful fear of family or relationship disintegration.

There should be little doubt that these men were vulnerable when faced with these frustrations. According to the Longman Dictionary of Contemporary English (1998), "vulnerable" is used to describe a person or their feelings and suggests that s/he is easily harmed, hurt or wounded or that s/he is sensitive. In my view, the vulnerabilities of these men can be categorized into the following four types or sources.

1. Vulnerability to unhealed emotional wounds from past experiences — Owing to their miserable personal and family experiences, the men carried heightened and reparative expectations in their intimate relationships and they were easily harmed by re-invoked feelings of the past wounds.
2. Vulnerability to the impact of life and family events — The various life events in relation to one's loss of health, employability, money, death, freedom, children's well-being and so on were certainly an assault to an individual's self-esteem or identity.
3. Vulnerability to the frustrations in an intimate relationship — Their partner's provoking responses in their daily interactions and especially at times of critical situations presented another assault to their self-esteem.
4. Vulnerability to jumbled, overwhelming emotions — When the emotions arising from the various frustrations were jumbled together, they could be overwhelming and presented a serious challenge to the men's emotional integrity.

As suggested by the variation in their background experiences and the frustrations encountered by these men in their family development, the significance of each of these vulnerabilities and their combined effects could vary from one man to another. It follows that in understanding the vulnerable face of a male batterer and his emotional frustrations, we need to have an in-depth and integrated exploration of the different types of vulnerability in his particular case. For example, TIN's case represented a situation that provoked all the different types of vulnerabilities. His past experiences of leading a lonely and rejected life had fostered in him heightened family expectations and at the same time a dreadful fear of family disintegration occuring again. But he had all along been frustrated by the intimate relationship with his wife and in the past several years, he was confronted with a number of negative events, including the loss of his fortune and the delinquent behaviour of his older daughter. His poor management only resulted in a jumble of the various frustrations and also the ensuing emotions which threatened to overwhelm him.

The present analysis has pointed to the role of relationship expectations and the men's emotional frustrations. In this regard, the body of literature on attachment processes and emotions in couple relationships has particular relevance in understanding men and their emotional behaviour in an intimate relationship. According to the attachment theory (Feeney 1999; Hazan and Shaver 1987; Shaver et al. 1988; Mikulincer et al. 2002), couples in intimate relationships have an internal working model of the relationship and how they expect to be treated. Couples typically expect their partners to be attentive, responsive and supportive especially in times of stress. In handling a negative emotional experience, an individual develops different strategies as a result of past attachment experience and repeated experiences of regulating distress with the partner: handling negative feelings in a relatively constructive manner by acknowledging distress and turning to the partner for support (referred as secure attachment); resorting to self-reliance as a way of reducing conflict with the rejecting or insensitive partner (referred as avoidant attachment); heightened awareness and expression of negative feelings as a way of maintaining contact with the inconsistent partner (referred as ambivalent attachment).

In particular, Johnson et al. (2001; Johnson, 2004) have proposed the construct of *attachment injuries* which "occurs when one partner violates the expectation that the other will offer comfort and care in times of danger or distress… is characterized by an abandonment or by a betrayal of trust during a critical moment of need…and is continually used as a standard for the dependability of the offending partner" (p. 145). According to Johnson et al. (2001), "Wounds to attachment relationships that result from emotional unresponsiveness at times of intense need may be equated to trauma with a small 't'... Following traumatic abandonment, the entire relationship often becomes organized around eliciting emotional responsiveness from the other partner, or defending against the lack of this responsiveness" (p. 150). Such postulation is particularly applicable to some of the men in my research sample who put up strong and violent protests at their partner's provoking responses at a time when they were going through some personal and family crises.

Emotional management, violent behaviour and masculine anxiety

The above analysis suggests that the male batterers were exposed to a number of vulnerabilities or injuries and had difficulties in managing the emergent emotions which at times threatened to overwhelm them. These overwhelming emotions may then fuel their aggression towards their respective partners or explode occasionally into extreme violence towards the partners.

So far in my review of the literature, Goldner and her associates (1990) have provided the most compelling account of how the men's emotions conduced to an outbreak of violence. Goldner et al.'s theory rests on the premise that the construction of gender and gender difference is a universal principle of cultural life that manifests itself in the individual psyche, the metaphysical framework, and the ideologies of a society. There is a taboo against the similarity between men and women and the dread of the collapse of gender difference operates silently and powerfully in all relations between men and women. These fears are normatively central to the development of men's masculinity and they are socialized to be different and stronger than woman, to control and overpower, and to deny their dependency needs and weak, "feminized" feelings. However, in the romantic alliance between a man and a woman, there is an illusion of a collapse of gender differences in their love relationship — men are allowed to express need or vulnerability without dishonour and women are allowed respect and dignity to their voice. But when the man is pushed to an intolerable feeling of similarity to the woman, he is terrorized by the weak, "feminized" feelings and will reassert his masculine difference and dominance by resorting to violence.

Regarding men's reparative expectations that the intimate relationship might provide healing to their emotional wound and suffering, Goldner et al.'s postulation regarding the men's illusion about the collapse of gender differences between the couple has gained some support in the men's cases. Moreover, Goldner et al.'s postulation regarding the men's difficulties in accepting their weak, "feminized" feelings is in general supported in the research sample. When faced with various frustrations, the emotions most frequently expressed by the men in the studies were the different versions of "anger" and "temper" (嬲、谷鬼氣、火遮眼、燥、脾氣一燥、脾氣唔好、脾氣暴躁、扯火、火滾、燒火、火爆、頂唔到、頂唔順、忍無可忍、忍唔住、無辦法忍到), and these emotions had apparently fueled the men's aggression towards their partners or, in Goldner et al.'s theory, their reassertion of masculine difference and dominance.

However, important and applicable as the gender concept may be, the present analysis has pointed to several deviations from Goldner et al.'s theory. First of all, as discussed earlier, the majority of couples did not develop an intimate relationship based on romantic love. Instead, in their mostly functional union with their partners, it was "family" that played the significant role of tying them together and fostering the couple's expectations towards each other. Family played a significant role in these men's self-development such that it became part and parcel of their identity. Secondly, in addition to the four sources of vulnerabilities for these men, Goldner et al.'s postulation points to another type of vulnerability harboured by the men at a deeper, unconscious level — vulnerability to being similar to women. But important as the role of this gender-based vulnerability in male battering behaviour may be, the role of other more generic vulnerabilities should not be overlooked. More importantly, when they are exposed to life and family events in an intense intimate relationship, how much difference is there between members of the opposite sex? Could there be more similarities than differences? Could there be a wide variation even within members of the same sex? Thirdly and finally, contrary to Goldner et al.'s postulation, some men in this research sample were not in denial about their weak feelings and need for support in front of their partners. Instead, it seemed to be their partners who did not acknowledge or even reject their expressed feelings and emotional needs. Therefore, in my view, as much as there are gender differences in the men and women's acceptance and expression of their feelings and needs, there are also important differences in how their expressed feelings are accepted or rejected by their partners. Could it be that while a woman's expression of her vulnerable feelings and needs tends to be accepted by others, a similar expression by a man tends to be ignored or rejected even by his intimate partner?

Interplay of the Men's Vulnerable and Chauvinistic Faces

In this research, I have defined the chauvinistic face as the men's explicit beliefs in terms of the following: that men are superior to women based on their gender per se; that men should be heads of the family and women should be subservient to their husbands; that men should be breadwinner and women should be housewife of the family; and that violence is a legitimate means for men to overpower women in the intimate relationship.

Analysis shows that not all of the men in this sample endorsed these patriarchal values and there was apparent variation for the men who held these beliefs. For example, on the mild end, except for the traditional sex-role differentiation, TIN did not exhibit any of the other patriarchal values. In fact, all the men in the sample held on to the traditional sex-role differentiation in the family: men as breadwinner and women as housewife. On the severe end, the men held a blanket view regarding men's superiority to women whether within or without the family and endorsed the use of violence in the relationship.

For those men who held explicit and strong patriarchal values, they on the one hand felt justified in asserting domination and control in the relationship and, on the other hand and perhaps more importantly, hinged their emotional comfort upon their wife's subservience. However, like any other man in the research sample, these patriarchal men were prone to various vulnerabilities in their personal and family development; and their patriarchal domination provided a deadly cover for their vulnerabilities. Contrary to their wish to find emotional comfort in the intimate relationship, their gender superiority beliefs made them more vulnerable in several ways. First of all, when faced with rejection and challenges from their wives, they were susceptible to feeling that their leadership was threatened and themselves being humiliated. Secondly, since their emotional comfort hinged upon the care and subservience of their partners, they were further alienated and wounded at times of confrontation with their partners who could hardly be caring and subservient to them at times of confrontation. Thirdly, when these men were struck by jumbled, overwhelming emotions and therefore came close to their weak, "feminized" feelings such as sadness, inadequacy and shame, the similarity with women posed a great threat to these men who believed that they were superior to women (Goldner et al. 1990). Moreover, in dealing with their emotional frustrations and vulnerable feelings, instead of advancing their self-understanding and self-care, they tended to adopt a moralistic view and focus on the wife's violation of their relationship virtues (不守婦道、唔識做人老婆), and their patriarchal beliefs provided them a dominant justification to release their anger and other emotions through aggression towards their partners. But their aggression could hardly provide any comfort but only further alienated their wives from them, therefore aggravating the marital conflict and leading to further frustration.

For those men who adhered rigidly to the traditional family gender roles of men as breadwinners and women as being responsible for childcare and household chores, they became vulnerable when their family role as sole breadwinner of the family was challenged by the rapid social and economic changes such as the economic downturn and subsequent change in the economic structure of the society, the rising unemployment rate and the increasing work demands, the increasing participation of women in work and social settings outside home, and the society's growing recognition of gender equality values. It was obvious that these men faced a crisis in adjusting their identity to the many changes as well as the accompanying emotional frustrations.

Treatment and Research Implications

To understand male battering and thus design the appropriate treatment strategies for the male batterers, the findings of the men's vulnerabilities and emotional injuries in this research study demand us to go beyond the focus on the male batterers' "violent face" and touch on their "non-violent faces" in the context of their personal and family development. These men may have a number of vulnerabilities as mentioned earlier — vulnerability to unhealed emotional wounds from the past experiences, vulnerability to the impact of life and family events, vulnerability to the frustrations in the intimate relationship, vulnerability to jumbled and overwhelming emotions, and vulnerability to being rejected in expressing their "feminized" feelings — which operate through the men's developmental experiences in the past, values attached to family, expectations of the intimate relationship, and management of emotional frustrations.

Owing to these vulnerabilities, the men may feel being wronged during confrontation and their violent outburst is an attempt to protect themselves from being wounded emotionally by their partners or otherwise. In this act of protection, they are likely to be immersed in their hurtful feelings, seeing themselves as being wounded and justifying their violent reaction as an inevitable self-defense. As a result, it would be difficult for them to look at or experience their behaviour from another angle, that is, the violent and controlling side of their self-protective behaviour as well as reparative expectations in the relationship. This may explain the frequent observation by many frontline workers that many batterers when being interviewed present themselves as "victims" and harbour a lot of resentment towards their partners and/or helping professionals.

In working with these men, helping professionals indeed run the risk of "victimizing" the men for not being able to understand or empathize with their miserable experiences, for focusing mainly on their violent and controlling behaviour, for viewing their disclosure through the lens of denial or minimization, and so on. In my view, in order to establish the connection and therefore the basis for intervention with these men, we need to adopt a "both-and" approach: While their aggression is not to be accepted and themselves not to be exonerated from the responsibility, their miserable experiences and resentment should be heard with empathy and with a view to understanding the vulnerabilities that may underlie their violence. Such empathic understanding may provide not only ventilation of their pent-up emotions but also space for the men to reflect on their own experiences.

However, notwithstanding this empathic understanding, we have yet to further research on the specific relationship of the men's various emotions with their violent outbursts in the intimate relationship. The men in this research had expressed a multitude of feelings in response to their frustrations, with anger or short-temperedness (in its wide variation) being the most apparent association with the men's violent behaviour. The questions are: Which types of anger are particularly prone to violent outbursts? What are the roles of other emotions (such as shame, jealousy, hatred, depression) in contributing to these angry emotions and/or violent outbursts in an intimate relationship? Finally and most importantly, what is an effective, alternative management of these emotions?

Moreover, in relation to the men's emotions, it was found in this research that certain types of issues may be particularly volatile and hurtful to the men. Of particular relevance here is the construction and socialization of family values in our society. These issues demand our critical research and reflection in order to have a more in-depth understanding of their effects on these men's responses and violent outbursts. For example, in the area of extramarital affairs, what is the underlying process for TANG's jealousy and controlling behaviour towards his wife? Similarly, in the area of in-law conflicts (such as TUNG's case), what is the underlying process for one partner's resentment towards the other for her/his refusal to attend the funeral of his/her deceased parent?

Conclusion

This chapter presents the findings of the family-only male batterers' vulnerabilities and emotional injuries in the context of their personal and relationship development. The findings defy the understanding of male battering that focuses only on their aggression and its control. They also call for further reflections on our understanding of the various emotional frustrations revealed by these men and challenge us to provide them with the appropriate management strategies.

Notes

1. The data was obtained from the Census and Statistics Department, HKSAR Government (www.info.gov.hk/censtatd).
2. The figures were obtained by my enquiry with the Census and Statistics Department of the HKSAR Government. The figures were based on (1) the number of successful applicants of the Certificate of Absence of Marriage Record (CAMR) for the purpose of marrying in the mainland of China (15,073 and 13,211 in 1986 and 2001 respectively) and (2) the number of marriages registered in Hong Kong with brides from the Mainland (703 and 5,169 in 1986 and 2001 respectively). However, since successful applicants of CAMR may not eventually lead to marriages, the total figure only gives a crude indicator of the total number of marriages.
3. See note 2. For the sake of comparison, the total number of marriages registered in Hong Kong were 43,280 and 32,825 in 1986 and 2001 respectively, according to the Census and Statistics Department of the HKSAR Government.

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Part IV

Health and Medical Trauma

Watching a peaceful death of a human being reminds us of a falling star; one of a million lights in a vast sky that flares up for a brief moment only to disappear into the endless night forever.
– Elizabeth Kubler-Ross, 1926–2004

9

Understanding Psychological Distress for People Recovering from Severe Acute Respiratory Syndrome in Hong Kong

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The chapter explores the complex relationships among mood, cognitive functioning, and subjective memory in medical-related trauma. Forty-one patients who had contracted the severe acute respiratory syndrome (SARS) were interviewed about two months after their discharge. Disruption areas, social support, and emotional distress were assessed. Out of this group, 23 patients aged between 20 to 34 were further assessed for cognitive functioning. The number of disruption areas and the lack of satisfaction with social support were found to be significant correlates of psychological distress. Though no group differences were found in the cognitive test performance, patients with subjective memory complaint reported a higher level of anxiety than those without. Discrepancies between subjective memory complaint and cognitive test performance are in line with those observed in other neurological patients. Results were discussed in the context of developing appropriate psychological intervention in the rehabilitation of patients recovering from medical trauma. Issues highlighted include the need to attend to the patient's social and tangible resources and to identify anxiety reactions which can affect the subjective sense of competence in rehabilitation.

There has been increasing interest in the post-trauma experiences as an internal event to the person caused by the onset of severe physical illness. The onset of physical illness may be sudden, unexpected and immediately life-threatening like stroke or myocardial infarction. The potential for psychological reactions to these events can be comparable to other traumatic reactions. Post-trauma reactions often include intense feelings of helplessness and high levels of anxiety and uncertainty about the future (Tedstone and Tarrier 2003). It is important to understand these reactions as they can act as a trigger for a range of responses which in turn will affect interventions and rehabilitation (Alonzo 2000).

Severe acute respiratory syndrome (SARS) was the name given to this disease at that time because patients suffering from SARS had flu-like and respiratory symptoms; for example, fever, cough and difficulty in breathing (Donnelly et al. 2003; Lee et al. 2003). SARS attacking human lungs has been considered as atypical pneumonia; tomography and chest radiographs of the SARS patients disclosed multiple areas with peripheral ground-glass appearance and consolidation on the lung, causing different degrees of lung injury (Lau et al. 2005). This disease was later found to be caused by a novel coronavirus (SARS CoV) (Peiris, Yuen, Osterhaus, and Stohr 2003). Due to its anonymity in the past and limitations in the knowledge of medical treatment, the whole world was under threat. By July 2003, SARS had broken out globally. The World Health Organization (2003) showed that 29 countries had been already affected by this disease. More than 8,400 cases were reported worldwide.

In Hong Kong, 299 SARS patients passed away out of 1,755 reported cases. The coronavirus of SARS can be transmitted by several ways such as close person-to-person contact, the spread of an infected person's respiratory droplets through coughing or sneezing, or touching the surface of objects contaminated with the SARS virus. Because of its high contagiousness, infected patients must be isolated from the community; even their families could not be allowed to see them. SARS brought a huge physical and psychological impact on these patients. Several studies have been carried out to investigate psychological distress in SARS survivors discharged from different hospitals after one or three months (Cheng, Wong, Tsang, and Wong 2004; Sheng, Cheng, Lau, Li, and Chan 2005; Wu, Chan, and Ma 2005a; Wu, Chan, and Ma 2005b). These studies adopted self-administered questionnaires as a method to assess psychological adjustment in these survivors. The results of these studies revealed that the discharged patients had anxiety and depressive features, and the degrees of psychological distress were dependent on psychosocial variables such as gender, occupation, and social satisfaction. The scores obtained by the discharged patients from either of these questionnaires suggested that they had moderate to severe anxious and depressive symptoms. In the following, we will report on two studies exploring the relationships among psychological distress, cognitive functioning, and subjective memory among recovering SARS patients.

With the infectious nature of this new disease, SARS can have many behavioural and emotional implications for recovering patients. The recovery phase of those who managed to be discharged may continue to be punctuated with fears of possible recurrence of illness and the elusiveness of a complete recovery (Au et al. 2004). Patients recovering from SARS are also possibly challenged with social prejudice and negative stereotypes. There is no universally established treatment regime, and the disease may reappear (Pearson, Clarke, Abbott, Knight, and Cyranoski 2003). The fears of contracting the SARS virus could potentially fuel the shunning of persons with SARS and cause difficulties for the infected individuals in getting the support they need (Bastardo and Kimberlin 2000). Thus, uncertainty and stigmatization are prominent themes in the longer-term emotional adjustment in SARS (Gorodzinsky 2003; Maunder, Hunter, and Vincent 2003).

At the same time, a treatment protocol including a combination of ribavirin and systemic steroids was adopted from the beginning of the epidemic, and the protocol is currently being reviewed (Chan, Ng, Chan, and Mok, 2003; So, Lau, and Yau 2003; Yuji 2003). Memory problems have been reported during steroid administration. This ranges from mild problems in verbal memory to severe dementia. The existing literature suggests that many of these effects are transient and reversible (Brown and Chandler 2003; Newcomer et al. 1999). However, some recovering SARS patients receiving outpatient follow-up care in our specialist clinic have continued to report a subjective sense of memory difficulties. So far, there is very little data on the cognitive functioning of patients recovering from SARS who have received steroid therapy in Hong Kong. Thus, the purpose of the study was to explore the relationships between psychological distress, subjective memory complaint, and objective cognitive test performance.

Method

Participants

Forty-one participants were recruited from 90 outpatients attending the SARS Clinic of Queen Elizabeth Hospital. At the time of their regularly scheduled appointments in the clinic, patients were invited to an interview with a clinical psychologist. After being briefly outlined the purpose of the assessment and giving written consent, participants were invited to complete self-administered questionnaires. Out of this group, 23 patients (aged between 20 to 34) recruited from the Outpatient Clinic of Queen Elizabeth Hospital were further assessed on cognitive functioning. The age group chosen was based primarily on the availability of local test norms for that particular age group which is also the primary reference group of the established Wechsler scales (Wechsler 1981). All consenting patients were seen about 1 to 2 months after discharge from hospital. One patient did not turn up for the scheduled appointment stating that there was no need for assessment.

Demographic characteristics were collected through the questionnaire. Illness and treatment related information including medication was obtained from the medical record. For the subjective memory complaint, each participant from the selected age group was asked “Do you have trouble with your memory?” The answer “yes” or “no” was recorded. This one question has been previously proven to be a sensitive and valid method to assess memory complaint in Chinese-speaking population (Wang, Wang, Fuh 2000). Based on the response to this question, 12 patients were allocated to the group with subjective memory complaint (SMC+), and 11 were allocated to the group without subjective memory complaint (SMC-).

Measures

Disruption Scale (DS)

Scales have often been used to identify areas of stress-causing disruption experienced by patients with acute onset of severe illness. Adopting from existing stress scales for severe illness (Devins and Binik 1996), 6 possible areas of disruption were identified for the present patients recovering from SARS: physical functioning, work/job functioning, interpersonal functioning, finance, and social discrimination. There is one final item for participants to list any additional disruption areas they experienced that are not covered. The number of areas of stress is aggregated into a total stress count score with a minimum of zero and a maximum of six.

Revised Social Support Questionnaire (SSQR)

The SSQR (Sarason, Sarson, and Grunug 1997) comprises 6 items tapping on the number of available others and degree of satisfaction for the particular kind of support stated in the question. The 4-point Likert scale ranged from “not satisfied” to “very satisfied”. The internal consistency of both dimensions was reported to be 0.90 and 0.93 respectively.

Hospital Anxiety and Depression Scale (HADS)

The HADS was chosen to provide a relatively comprehensive and sensitive measure of psychological distress. The HADS (Zigmond and Snaith 1983) consists of fourteen items from which two independent scores are calculated for anxiety and depression. Ranging from 0 to 21 for each of the two scales, low scores reflect absence of anxiety and/or depression. The scale was partially validated in Hong Kong, and the Chinese version demonstrated good agreement with the original English version (Leung, Ho, Kan, Hung, and Chen 1993; Sze, Wong, Lo, and Woo 2000).

Wechsler Scales and Hong Kong List Learning Test

The Chinese translated version of the Wechsler Adult Intelligence Scale-Revised (WAIS-R) was used to assess general intellectual functioning (Chan, Lee, and

Chan 2000; Wechsler 1981). As for testing of memory, the Hong Kong List Learning Test (HKLTT) was employed to measure verbal memory (Au, Chan, and Chiu 2003; Chan and Kwok 1999), and the Visual Reproduction (VR) subtest of the Wechsler Memory Scale-Revised (WMS-R) was used to evaluate visual memory (Wechsler 1987).

Statistical analysis

Firstly, the following data was explored on a descriptive basis: demographic characteristics, illness-related factors, DS, SSQR and HADS. Secondly, Pearson product-moment correlation coefficients were computed to explore the relationships between HADS on one hand and demographic characteristics, the illness-related and psychosocial variables on the other hand. Hierarchical regression was conducted to determine the most relevant correlates of the HADS measures. Finally, an attempt was made to identify the characteristics of high scorers on the HADS.

Secondly, further analysis was done for the 23 patients who went through cognitive testing. The WAIS-R yielded six raw scores, one for each subtest. The VR of the WMS-R produced two measures: immediate recall and 30-minute delayed recall. For the HKLTT, learning over three trials was added up to form a total learning score. The HKLTT delayed recall was based on the number of words recalled after 30 minutes. The raw scores of the WAIS-R and the HKLTT were converted into percentiles according to the available Hong Kong Chinese norms (Chan and Kwok 1999; Chan et al. 2000). The scores for the WMS-R (VR) were converted into percentiles according to the norms given in the manual. The HADS yielded scores for 14-items from which two independent subscale scores were calculated for Anxiety and Depression. Subjects were divided into two subgroups according to the presence or absence of subjective memory complaint. *T*-tests were performed to investigate group differences in emotional state and objective measures of cognitive functioning. The SPSS program for Windows, Release 7.0, was used for all analyses.

Results

Demographic characteristics and illness-related variables

Patients were seen on average 55.81 days (SD = 15.77) after their discharge from the hospital. Results obtained are summarized in Table 9.1.

Table 9.1 Demographic characteristics and illness-related factors of the patients recovering from SARS ($N = 41$)

Variables	Frequency (Percentage)	Mean (*SD*)
Sex		
Male	19 (46.34)	
Female	22 (53.66)	
Age		35.85 (11.15)
20–29	12 (29.27)	
30–39	16 (39.02)	
40–49	8 (19.51)	
50–71	5 (12.20)	
Education		13.19 (5.10)
Employment		
Employed	22 (53.55)	
Unemployed	19 (46.34)	
Marital Status		
Married	19 (46.34)	
Single	18 (43.90)	
Divorced/Widowed	4 (9.76)	
Witnessing a significant other contracting SARS	12 (29.27)	
Bereaved of a significant other who died of SARS	6 (14.63)	
Bereaved of spouse who died of SARS	2 (4.87)	
Length of hospitalization		28.17 (19.09)
ICU admission		14.00 (34.15)
Six Minute Walk Test		
Category 2	25 (60.98)	
Category 3	16 (39.02)	

Note: *SD* = Standard deviation.

HADS, Disruption areas and SSQR availability and satisfaction scores

The means and standard deviation are listed in Table 9.2. Using the cut-off score of 11 suggested in the manual, 12.1% of the patients were classified as moderately to severely anxious while 12.1% of them were classified as moderately to severely depressed. The number of endorsed disruption areas ranged from 0 to 6 with a mean of 1.70 (*SD* = 1.75). Among the 6 areas, physical functioning was the most frequently reported. Over 20% of the patients indicated disruption in finances, work/job, and interpersonal functioning. For the SSQR, the mean satisfaction with social support across 6 items was found to lie between "quite satisfied" and "only a little satisfied".

In terms of demographic variables, only age was found to show significant correlation with the HADS scores. No significant correlations were observed between the HADS scores and illness factors including the length of hospital stay, ICU admission, and the Six Minute Walk Test (American Thoracic Society 2002). On the other hand, the HADS scores were found to correlate significantly with the number of disruption areas and the SSQR social satisfaction score. However, the HADS scores did not correlate with the social availability score (Table 9.3). In other words, higher anxiety and depression scores were associated with the number of disruption areas reported. Lower anxiety and depression scores were associated with a greater level of satisfaction with social support.

Table 9.2 The results of the Disruption Scale, SSQR and HADS ($N = 41$)

Variables	Frequency (Percentage)	Mean (*SD*)
Disruption Scale		
Number of disruption areas		1.71 (1.75)
0 areas	8 (19.51)	
1 area	22 (53.66)	
2 areas	0 (0.00)	
3 areas	3 (7.32)	
4 areas	2 (4.87)	
5 areas	5 (12.20)	
6 areas	1 (2.44)	
Nature of disruption areas		
Physical functioning	26 (63.41)	
Work/job functioning	10 (24.39)	
Interpersonal functioning	10 (24.39)	
Emotional functioning	8 (19.51)	
Finance	11 (26.83)	
Discrimination/ prejudice	5 (12.20)	
SSQR		
Availability of social support	3.04 (2.21)	
Satisfaction with social support	2.73 (0.58)	
HADS		
Anxiety	6.00 (3.74)	
Depression	5.24 (4.39)	
Adjusted Depression	4.64 (4.52)	

Note: *SD* = Standard deviation.

Table 9.3 Bivariate correlations of age, number of disruption areas, social availability, and satisfaction with the HADS scores

	HADS		
	Anxiety	**Depression**	**Adjusted depression**
Age	0.60**	0.64**	0.62**
Number of disruption areas	0.62**	0.69**	0.70**
SSQR			
Availability of social support	0.07	-0.15	-0.12
Satisfaction with social support	-0.59**	-0.68**	-0.67**

** $p < 0.01$.

Hierarchical regression

To reduce the number of predictors, only variables that showed significant bivariate correlation with the HADS scores were included in the regression analysis. The three independent variables included age, disruption areas, and satisfaction with social support. The three variables were grouped into two blocks: age and psychosocial variables. The psychosocial block included both the number of disruption areas and social satisfaction. Sequential regression was employed to examine the contribution of psychosocial variables to the HADS scores after controlling for age. Thus, age was entered as the first block and the psychosocial variables as the second block. The dependent variables were the HADS Anxiety and Depression scores. After controlling for age, the psychosocial variables were found to contribute significantly to the HADS scores, accounting for 17.0% of the variance for the HADS Anxiety score, 24.4% of the variance for the HADS Depression score, and 26.0% of the Adjusted Depression score. An examination of the standardized beta coefficients suggested that both the number of disruption areas and social satisfaction demonstrated significant associations with all the three HADS scores (Table 9.4).

Results for the subgroup tested for cognitive functioning

Demographic characteristics and medical information of the two groups (SMC+ versus SMC-) are summarized in Table 9.5. The two groups were largely comparable in the variables described. However, the age was higher in the group with subjective memory complaint than that in the group without, $t(22) = -2.80$, $p < 0.05$. Table 9.6 summarizes the results on the WAIS-R, HKLTT and WMS-R (VR). Outcomes on the HADS are summarized in Table 9.7. No significant

Table 9.4 Summary of regression analysis for predicting the HADS scores ($N = 41$)

Regression analysis for predicting HADS Anxiety Score ($N = 41$)

		Standardized	β coefficients	R	R^2	R^2 change	F change
		Step 1	Step 2				
Block 1	Age	0.60	0.24	0.60	0.36	0.36	21.62**
Block 2	Psychosocial variables			0.72	0.52	0.17	6.52**
	Number of disruption areas		0.35*				
	Social satisfaction		-0.28*				

Regression analysis for predicting HADS Depression Score ($N = 41$)

		Standardized	β coefficients	R	R^2	R^2 change	F change
		Step 1	Step 2				
Block 1	Age	0.64	0.21	0.64	0.41	0.41	27.32**
Block 2	Psychosocial variables			0.81	0.65	0.24	13.09**
	Number of disruption areas		0.39**				
	Social satisfaction		-0.37**				

Regression analysis for predicting HADS Adjusted Depression Score ($N = 41$)

		Standardized	β coefficients	R	R^2	R^2 change	F change
		Step 1	Step 2				
Block 1	Age	0.62	0.17	0.62	0.38	0.38	24.23**
Block 2	Psychosocial variables			0.80	0.64	0.26	13.35**
	Number of disruption areas		0.42**				
	Social satisfaction		-0.36**				

* $p < 0.05$; ** $p < 0.01$.

differences between the two groups were identified in the objective test performance. Furthermore, the test scores for both groups are all in the normal range. Regarding the HADS, no significant differences in the Anxiety and Depression subscale scores were obtained. Again, the scores for both groups are in the normal range. However, the group with subjective memory complaint was found to score significantly higher in Item 3, t(22) = -2.35, $p < 0.05$. For this item, patients were asked to rate in to what degree they "got a sort of frightened feeling as if something awful is about to happen". Higher score on the item indicates greater anxiety.

Table 9.5 Demographic characteristics and medical information of the two groups: patients with subjective memory complaint (SMC+) versus those without (SMC-)

	SMC+ Group (*n* = 12)		**SMC- Group (*n* = 11)**	
	Frequency	**Mean (*SD*)**	**Frequency**	**Mean (*SD*)**
Age		30.92 (2.07)		26.92 (4.30)*
Sex				
Male	3		7	
Female	9		4	
Education		13.83 (2.79)		13.73 (2.61)
Employment				
Employed	1		1	
Unemployed	11		10	
Marital status				
Single	5		6	
Married	6		5	
Widowed	1			
Time since onset (days)		71.00 (12.64)		86.00 (21.95)
Time since discharge (days)		43.67 (16.85)		56.10 (21.31)
Period of hospitalization (days)		27.18 (12.24)		27.80 (17.00)
Need for Admission into Intensive Care Unit				
Yes	2		2	
No	10		9	
Need for Intubation				
Yes	3		2	
No	9		9	
Prenisolone equivalence (mg)		2059.08 (1045.13)		1840.86 (1006.50)

Note: *SD* = Standard deviation; *$p < 0.05$.

Table 9.6 Objective test performance of the two groups: patients with subjective memory complaint (SMC+) versus those without (SMC-)

	SMC+ Group (*n* = 12) Mean (*SD*)	**SMC- Group (*n* = 11) Mean (*SD*)**
Wechsler Adult Intelligence Scale-Revised		
(in percentile)		
Digit Span	83.82 (28.03)	96.85 (7.41)
Arithmetic	47.50 (28.09)	50.55 (27.92)
Similarities	47.00 (28.08)	41.27 (26.05)
Picture Completion	43.68 (22.06)	50.55 (29.62)
Block Design	49.17 (27.89)	59.45 (27.70)
Digit Symbol	59.50 (29.44)	54.91 (33.50)
Hong Kong List Learning Test		
(in percentile)		
Total Learning	58.61 (16.48)	55.90 (23.64)
Delayed Recall	59.17 (26.20)	62.00 (24.20)
Wechsler Memory Scale-Revised (Visual Reproduction)		
(in percentile)		
Immediate Recall	83.08 (15.79)	90.91 (11.36)
Delayed Recall	80.75 (21.62)	87.73 (17.41)

Note: *SD* = Standard deviation.

Table 9.7 Emotional state profile of the two groups: patients with subjective memory complaint (SMC+) versus those without (SMC-)

	SMC+ Group (*n* = 12) Mean (*SD*)	**SMC- Group (*n* = 11) Mean (*SD*)**
Hospital Anxiety and Depression Scale		
(Raw scores)		
Anxiety	5.42 (3.00)	3.45 (2.73)
Depression	3.50 (3.85)	2.18 (2.40)
Item 1	0.92 (0.67)	0.45 (0.69)
Item 2	0.67 (0.89)	0.45 (0.52)
Item 3	1.08 (0.79)	0.36 (0.67)*
Item 4	0.08 (0.29)	0.18 (0.40)
Item 5	0.75 (0.75)	0.81 (0.60)
Item 6	0.58 (0.90)	0.45 (0.52)
Item 7	0.83 (0.72)	0.64 (0.50)
Item 8	1.08 (0.51)	0.82 (0.75)
Item 9	0.75 (0.45)	0.45 (0.52)
Item 10	0.25 (0.45)	0.18 (0.40)
Item 11	0.42 (0.51)	0.27(0.47)
Item 12	0.67 (0.98)	0.18 (0.40)
Item 13	0.75 (0.75)	0.64 (0.67)
Item 14	0.17 (0.39)	0.00 (0.00)

Note: *SD* = Standard deviation; *$p < 0.05$.

Discussion

The present study documented the association between anxiety and depression on one hand, and the number of disruption areas and satisfaction with social support on the other hand in the local patients recovering from SARS. The findings can be useful for at least two reasons. Firstly, as patients reported many potential concerns related to tangible areas like physical, financial, and interpersonal issues, individual psychological intervention should be provided in the context of a multidisciplinary team. Apart from dealing with the more traditional psychotherapeutic issues such as reducing negative thinking and instilling hope, patients should be empowered with the knowledge of where and how to get support with the tangible and practical issues. It has been well-documented that the lack of social support can aggravate post-trauma reactions due to medical illness (Tedstone and Tarrier 2003).

Secondly, the psychosocial correlates of distress among these patients can help frontline medical and nursing staff effectively identify the need for further intervention. Patients may find it easier to talk about disruption and social support rather than directly reporting anxiety and depressive symptoms. This can be a particularly important point as the suggestion of psychological and psychiatric disturbances may aggravate the sense of stigmatization and prejudice which has already been experienced by these patients. Therefore, as part of the holistic screening procedure during the follow-up, medical and nursing staff should ask patients about disruption or changes experienced in the daily lives as the result of SARS. The early identification of those at risk of developing more severe psychological reactions is important as these reactions have the potential of increasing further physical complications, non-compliance and lack of motivation in rehabilitation (Alonzo 2000). The subjective sense of frailty can lower the sense of personal control to return to the previous functioning and lifestyle. Levels of anxiety and depression have been found to correlate with the subjective sense of mastery in local epilepsy patients (Au et al. 2002).

It may be interesting to compare the present data on patients recovering from SARS with available data of other local patient groups. Patients with human immunodeficiency virus (HIV) and epilepsy may also have constant worries over physical deterioration or an imminent seizure attack. However, the chance of a complete recovery appeared higher for patients recovering from SARS than the chance for those with cancer, HIV and epilepsy. It is understandable that the level of emotional distress of the present patients recovering from SARS was lower than that of the newly diagnosed patients with HIV of whom over 10% had reported anxiety or depressive symptoms above the cutoff on the HADS (Au et al. 2008). In comparison with established epilepsy patients who have been diagnosed for over 10 years, the anxiety level of the patients recovering from SARS appeared relatively mild, while the depression levels were similar(Au et al. 2006). Nevertheless, the satisfaction with social support of the present patients recovering from SARS was shown to be significantly lower than that for the epilepsy cases (Au, Li, and Chan 2002). The limited knowledge of the transmission mode of SARS may have contributed to the social prejudice which in turn affected the social support available to patients recovering from SARS.

The study also explored the relationships of subjective memory complaint with objective test performance and emotional state in 23 patients recovering from SARS aged between 20 to 34. Comparing a group with subjective memory complaint and a group without the complaint, results did not reveal any significant differences in the objective test performance in terms of intellectual functioning and memory. The cognitive test scores and the mood scores for both groups are all in the normal range. However, the group with subjective memory complaint scored significantly higher on an anxiety item that described "a sort of frightened feeling as if something awful is about to happen". This is a rather interesting finding as apprehensive expectation is the cardinal feature of anxiety according to the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association 1994). These results would suggest that the subjective memory complaint could be related to anxiety. Diagnosis of neurocognitive problems often relies heavily upon patient's subjective complaints of cognitive difficulties in everyday life. Yet, the literature in the Western countries proposes that the relationship between subjective memory and actual memory test performance is a complex issue and that such complaints can be heavily influenced by affective factors. Discrepancies between subjective memory complaint and cognitive test performance in neurological patients have been frequently reported (Piazzini, Canevini, Maggiori, and Canger 2001). Subjective memory complaints were shown to be significantly related to anxiety and depression. These complaints, however, were not found to be related to objective memory test measures at all. Higher levels of subjective memory complaints were associated with greater levels of anxiety and depression.

Similar findings have been reported in other patient with epilepsy and HIV (Au et al. 2006; Au et al. 2008). Patients who over-reported tended to be more depressed than those who under-reported, whereas the fact that under-reporters had more significant genuine cognitive impairments. These results would suggest that subjective memory complaints are not completely reliable or accurate indicators of actual neuropsychological deficits. As a result, when a patient has memory complaints, a thorough assessment on both mood and neuropsychological functioning is needed in order to make better decisions about the possible occurrence of cognitive impairment or dementia. The present study is perhaps the first to document this discrepancy in patients recovering from SARS. Findings recommend that subjective memory complaint in these patients may be related to anxiety.

The present study has certain limitations. The subject size was relatively small and came from one local hospital. Plus, the age group was confined to younger patients. The choice of the age range was initially based on the availability of local test norms and the relative lack of other possible neurological complications in older adults. The current findings reveal that the patient group with subjective memory complaint was older than that of the other group. Future studies will need to examine the effect of age on subjective memory complaint. Other than that, a cross-sectional design was used, and no cause-effect inferences could be drawn. Indeed, a longitudinal study is needed to monitor long-term changes in stress and distress.

To conclude, the present study documented the relationship of psychological distress with disruption areas and the satisfaction of social support in a group of local patients recovering from SARS. A severe illness like SARS can cause major disruptions to activities in daily living. Patients recovering from SARS are also faced with social prejudice causing them difficulties in getting the support when they need it most. Comparison of the present data has also made with available data on other patient groups. In particular, the relative lack of satisfaction with social support of the present group of patients recovering from SARS has been highlighted. Furthermore, the present study also emphasized the possibility of the relationship between emotional factors and the subjective sense of competence in functional abilities. Although future studies need to deliberate on the specific relationships among emotions and subjective competence, the findings of the present study reinforced the need to take into account the emotional state in the recovery in these patients. Specifically, psychological intervention may need to help patients overcome their anxiety about their functional competence in rehabilitation. The clinical implications of the findings have been discussed in the context of developing appropriate intervention as well as assisting frontline staff in identifying the need for psychosocial support in patients recovering from SARS.

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10

Alleviating Pain of Death and Dying with Modern Palliative Care

Doris Man-wah Tse

Introduction

Death and dying in Hong Kong is highly medicalized and institutionalized. Every year, there are more than 36,000 deaths in Hong Kong, and one-third was caused by cancer. According to the Hong Kong Cancer Registry, there were 12,093 cancer deaths in Hong Kong in the year 2006. Hong Kong is also among one of the places with the highest life expectancy at birth in the world. In 2006, the life expectancy at birth of male was 79.4 years while that of female was 85.5 years.

Although cancer is the major cause of death, these patients also had other comorbid chronic illnesses at the time of death. Cancer, together with other chronic debilitating diseases of the heart, lung, kidney and the neurological system, accounted for half of the deaths in Hong Kong (Tse 2007a).

Death: What Is It?

Death is a state defined by medical terms, and with clear legal implications. Although dying could be a complex or lingering process, the moment of death has its own "simple" and specific definition. The common law standard for determining death refers to the cessation of all vital functions, traditionally demonstrated by "an absence of spontaneous respiratory and cardiac functions." The definition of death as approved by the American Medical Association in 1980 and by the American Bar Association in 1981 was: "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem is dead. A determination of death must be made in accordance with accepted medical standards."

Although death may seem to be an obvious term, defining death has been problematic all along. Proclaiming death of a person based on brain stem activities has generated controversies and critique on the pragmatism of adopting an organic based definition of death without referring to the complexity of the philosophical and spiritual aspects of an integrated human being or person (Seifert 2000).

Recognition of the End of Life

Death is a point of no return. As significant as the moment may be, it usually takes less than minutes for a doctor to pronounce its occurrence. Even a newly graduated doctor will have no difficulty in identifying a heart that has stopped beating, the lungs that have stopped breathing, and pupils that remain widely dilated even shone by a torch.

However, the prediction of when the end of life happens may not be that easy. No one single parameter, including the disease itself, the functional status or the biological parameters of the body, or the quality of living, can allow us to predict accurately the prognosis or the remaining time of life. The clinical trajectory of patients suffering from different illnesses can be different towards the end of life — from patients with a smoldering type of profile, dying from fragility and senility, to patients with a dramatically up-and-own profile, suffering from recurrent episodes of organ failure. In this era of advanced technology, a near-death state is sometimes reversible with timely medical intervention. Even for patients who suffer from incurable cancer, the new molecular targeted chemotherapy may prolong life in some patients who would otherwise be told "nothing can be done" in the past. The transition from a curative to a palliative care phase can be blurred, and the end-of-life state may come unrecognized.

Without appropriate prognostification and recognition of the end-of-life state, medical care will continue with curative intent. This can result in over-aggressive interventions which are inappropriate for patients with limited prognosis.

On the other hand, the diagnosis of cancer is often associated with a death sentence, while that of other chronic illnesses is regarded as a more fortunate situation. While this "allergic" association may be true for that particular diagnosis of cancer, the prognosis of some chronic debilitating illnesses may be optimistically biased. For example, information from the Canadian national data in 2001 showed that males aged 35 to 64 who were on long-term dialysis for end-stage renal disease had a 10-year survival rate of 40%, while that of the general population was 90%. This survival was only slightly better than those with colonic cancer, and slightly worse than those with prostate cancer.

Awareness of Death

Awareness of the diagnosis is one thing and awareness of the prognosis is another matter. Do patients want to know that they are dying? Putting aside the way this message is being conveyed, one can only have time for preparation if he or she is aware of the limitation in life span. In a survey of 738 Chinese adults in Hong Kong on their indicators of a good death (Chan, Chan, Tin, and Chan 2004), items that scored above 7 out of 10 on a 11-point rating scale included those requiring a process of preparation, for example, reconciliation with family, financial planning for family, fulfillment of last wishes, pre-arrangement of funeral, and psychological preparation for death. According to another local qualitative study on thirty-three Chinese palliative care patients by Mak (2001), awareness of dying was identified as the foremost element of a good death.

However, in a recent population-based survey on good death in Japan involving over 3,000 participants (Sanjo et al. 2007), 50% of them preferred some level of negotiation with the physician regarding prognostic disclosure. This preference was associated with the concept of "control over the future" in good death.

Suffering of the Dying

Death is universal. Although given a lifetime, one usually feels not quite prepared to die yet. Death seems remote and far away until it happens. In his book *The Healer's Calling* (1997), Sulmasy succinctly pointed out that "mortality and finitude is a forgotten message, illness is just the messenger." Advances in modern medicine have fostered humans' desire to overcome mortality, and perception of death as preventable at all costs. The bad news is a rude awakening, reminding humans of their vulnerability. Most patients cannot remember the contents of the bad news. However, many can vividly remember the manner in which it was delivered and the words that destroyed all hope and choices.

When thinking about suffering due to cancer, patients are often overwhelmed by the anticipatory or existing pain, as if pain is the hallmark of cancer. Studies have shown that cancer patients suffer from multiple symptoms in addition to pain. Pain, dyspnoea, fatigue, anorexia, nausea, vomiting, constipation, weight loss, cough, insomnia are among the common ones (Lo et al. 2002). In a local study on advanced cancer patients at the last week of life (Kwok, Tse and Ng 2005), patients reported multiple symptoms and among all, fatigue, cachexia and anorexia were among the most distressing ones. Indeed, these are often regarded as the triad of symptoms in patients who are imminently dying. Effective pain control evades the myth that cancer patients would be suffering from escalating pain when death is near.

Although it is traditional to assess these symptoms in terms of their intensity, frequency and duration, these symptoms should be evaluated in terms of the distress associated and their impact on the functional, social and psychological well being of the patient. The overall distress as experienced by the patient is subjected to his or her own appraisal as affected by multiple internal and external factors. It is therefore unique to the patient and has to be described in patient's own words. In addressing the distress and suffering from the symptoms, a multidimensional approach is required.

Case 1: Just a little pain

Chong was a 65-year-old gentleman who suffered from incurable lung cancer. He was diagnosed to have metastases of the liver while his primary lung cancer was of a small lesion in the right lung parenchyma. On his first visit to our palliative care clinic, he was ambulatory and with a satisfactory functional status. I did not expect his lung lesion to cause any significant pain, and indeed, he rated his pain over the right chest (where his lung tumour was lying in) as very mild in intensity, of grade 1 out of 10 in a numerical rating scale. The pain was also transient, and would subside spontaneously. However, the impact of this "mild" pain actually lasted for a disproportionate duration of at least 4 to 6 hours. Every time the pain occurred, Chong would fantasize about his cancer growing bigger. Instead of carrying out his social activities that he was perfectly able to do so, he would rather be alone at home, perplexing about his cancer.

The suffering of those dying is far beyond that of symptoms or the disease itself. The "disease" itself is not the focus of care, but should be the person living with the illness and dying from the illness. The idea that humans are dichotomized into "body" and "mind" (Descartes, 1596–1650), has deep-rooted influence on development of Western medicine. With this dichotomy, the body was left to medicine. We keep on fixing the body, with little awareness of the suffering of the whole person. Helping the dying involves recognizing the patient as whole person. One does not identify or remember the dying person by the disease he or she is dying from, but by who he or she was.

What is a person? This question has no easy answers, for which humans may be searching throughout the history of mankind. Early in 1950s, Dr Paul Tournier (1957) in his book *The Meaning of Persons*, elaborated how a human existed as a person, but appeared as the personage. The personage is an image that is related to external factors e.g. occupation, social status, roles, possessions, friendship and kinship, etc. As an external image, a personage can be deceptive and depersonalized. When one faces death and dying, the personage may be threatened and no longer sustainable. This is the time when the person faces his or her own inner person.

Half a century later, in the book *The Nature of Suffering and the Goals of Medicine* (2004), Dr Eric Cassell described a whole person as one consisting of the dimensions of physical body; behavioural pattern; roles and functions; relationship with self, others, and his/her god; past life experience and transcendence. When facing a life-limiting illnesses, suffering arises as there is an impending destruction of the person.

However, in clinical setting, it depends on the sensitivity, skills and knowledge of the physician to diagnose suffering as patient speaks in their own words (Tse 2004). These words are clues to how patients suffer as they loss their roles, appearance, functions, and relationships (Figure 10.1).

How a patient tells you …	**what he is suffering from**
"It hurts everywhere"	• multiple symptoms
"I don't look the same now"	• loss of image
"I'm no longer a good father"	• loss of role
"I can't do what I used to do"	• loss of function
"I am useless"	• loss of dignity
"I have no future"	• hopelessness
"I haven't told them I'm sorry"	• broken relationships
"I would rather die"	• loss of will to live
"Nobody can understand me"	• disconnectedness

Fig. 10.1 The nature of suffering in illness and suffering as a personal experience

Case 2: A lonely man

Ming was a 64-year-old gentleman who lived alone in Hong Kong. His family, including his wife and two children, were living in China. He was diagnosed to have basal cell carcinoma of his left face for 4 years before he was referred to our palliative care service. He underwent several surgeries to remove his tumour by then, but each time ended in recurrence and a more ugly-looking raw area on his left face, engulfing and eroding his left eye. He had a lot of anger towards his illness and the medical treatments that he had received. Despite being ambulatory, he chose to hide himself from his neighbours and his friends because of his wound, which was disturbing in appearance.

Ming resided in a public housing estate, in a flat which was meant for a family of four. As he suffered from a progressive illness, his wife brought the children back to China to distance themselves from him. During a home-care visit, the nurse, Michelle, was astonished by the "emptiness" of his flat. There was no *furniture, but only a bed without a mattress. Tables and chairs, ornaments and decorations, electric appliances — all so typical of a "home", were nowhere to be found. Relying on social security support, he had dedicated vast majority of the money to pay the rent. He refused to move to a smaller flat so that he could make more allowances for his own basic living. Ming dearly hoped that he could retain his role as a father and as a husband. The only thing that he wished for was a place for his family to stay if they came back to Hong Kong one day.*

Ming carried with him a strong sense of aloneness and loneliness as he appeared before our palliative care team. He could feel no one understanding him, as if he was disconnected from this world. The family was so valuable to him, and his act of doing something for his family had given him strength to live. By the time Ming died in our Palliative Care Unit, his wife and children had joined him in Hong Kong.[1]

The Modern Palliative Care Movement

The rise of palliative care in medicine is responding to a call for alleviating the suffering of the dying. This is referred to as the modern palliative movement, to distinguish from the "hospices" in the medieval age, where pilgrims were offered food and drink and care when they fell sick on their journey.

Palliative care, as defined by the World Health Organization (WHO), integrates physical, psychological and social care and provides relief from pain and other distressing symptoms. Palliative care affirms life and regards dying as a natural process; it neither hastens nor postpones death. Patients with life-limiting illnesses are supported to live as actively and fully as possible.

Instead of the traditional biomedical model adopted in modern medicine, palliative care is characterized by a paradigm shift to the biopsychosocial and spiritual model. In order to relieve suffering, patient should be seen as a whole person, who has own experience of suffering as a spiritual being. Therefore spiritual care is an integral part of palliative care. And therefore in the presence of an incurable illness and a decaying physical body, therapeutic activities are still possible. This is mediated by professionals with skill and knowledge, who can establish a therapeutic relationship with the dying through acceptance and compassion. Compassion is not pity and sympathy. Compassion compromises of three active steps (Sulmasy 1997): firstly, to recognize the contents of suffering objectively; secondly, to understand the experience of suffering subjectively; and thirdly, to help the one who suffers by words and deeds actively.

This palliative care movement is not simply a revival of the old practice in the middle ages, nor is palliative care an "enemy" of medical advances. Instead, the relationships between palliative care and medical advances are multifaceted.

Firstly, modern science is also important to palliative care development. The modern palliative movement does not stop at having a kind heart and a pair of warm hands. Given the vulnerability of the dying patients, it is just as important, if not more, for health care professionals to deliver care and practices that are substantiated by rationale, facts and evidences. Medical advances, apart from improving the chance of cure, can also improve symptom control in patients facing death. For example, knowledge and skills developed in cancer pain control have contributed significantly to ease suffering from pain from other diseases.

Secondly, palliative care is also applicable in places where high-technology medical services are offered, like the intensive care unit. More and more intensive care units have recognized the need of palliative care for patients who are dying there. Despite all the possible interventions, there will be a critical point when death is perceived as inevitable. Recognition of this critical point helps to shift the goals of treatment from cure to palliation, instead of continuing aggressive interventions relentlessly. In 2006, among the 1,503 patients who died in ICU in HA hospitals, half of them were above age 70 years and one-third had been on mechanical ventilation before death. Among the ICU deaths, half occurred within 2 days of admission. This rapid transition from an aggressive curative phase to the palliative end-of-life (EOL) care remains a challenge.

Thirdly, as there are more and more advances in technology, it is also important that palliative care should be developed in parallel. This is not just because palliation of symptoms is basic and fundamental, but also because patients should be given the choice and access in their care planning.

In the United States, where medical technology is on the leading edge, the nation also recognizes the need to address their quality of EOL care. The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT) was a multicentered trial of intervention to improve EOL care (The SUPPORT Principal Investigators, 1995). Phase I of this SUPPORT project consisted of a 2-year observational study, involving 4,301 seriously ill, hospitalized patients. Results showed that EOL care in hospitals was far from satisfactory. Only 47% of physicians knew their patients preferred no cardiopulmonary resuscitation (CPR); 46% of Do-Not-Resuscitate (DNR) orders were written only 2 days before death. Among all deaths in hospital, 38% of them spent at least 10 days in ICU. More than 50% of bereaved families reported moderate to severe pain in patients at least half of the time.

Phase II of this study was an intervention phase of 2-year duration, with 4,804 patients randomized to the control or treatment groups. Trained nurse facilitators were to provide active intervention to facilitate better EOL care. However, at the end of the study, no improvement was found in all the parameters studied. There was no improvement in communication and no change in practice at the EOL group, including no change in documentation of discussions regarding DNR and no change in the frequency of attempted CPR.

The goal of treatment changes as patients approaching the end of life. In one study on advanced cancer patients (McCarthy, Phillips, Zhong, Drew and Lynn 2000), they increasingly preferred not to have CPR and life-extending treatment as they approached death. They would prefer to die than spending time in coma or on ventilator. In one more recent study on 440 patients (Heyland et al. 2006) with advanced cancer and non-cancer illnesses, 55.7% of patients opined that "not to be kept alive on life support when there is little hope for recovery" as an important factor of quality end-of-life care. The preferences of seriously ill patients were also shown to be commonly shared by families and health care providers in another study (Steinhauser et al. 2000). The following items were common to them all as important factors for quality end-of-life care, including pain and symptom management, preparation for death, achieving a sense of completion, decision about treatment preferences, and being regarded as a whole person.

Rose et al. (2004) reported that fewer older patients prefer CPR or life-sustaining treatments. A local study (Hui, Ho, Tsang, Lee and Woo 1997) was also conducted on 543 elders, consisting of 382 elderly home residents and 161 in-patients of geriatric wards. Approximately 80% of elderly home residents and 60% of hospitalized patients had no knowledge of life-sustaining therapy. They overestimated the success rate of CPR, and up to 20% changed their minds and declined CPR when given facts about the outcome. A considerable proportion of older people wished to be involved in decision-making regarding life-sustaining treatment.

Palliative Care in Hong Kong

Palliative care service has been developed in Hong Kong since 1982 (Chan, 2002). It began at a small scale in Our Lady of Maryknoll Hospital, and coordinated by Hospital Authority to provide territory wide service since 1994. After 25 years of development, the major achievements can be summarized in 4 areas. First, a comprehensive range of service consisting of inpatient, outpatient, home-care, day-care and consultative service. There are about 40 beds per million for the general population. Second, territory-wide coverage serving more than 50% of cancer deaths per year. Patients were under palliative care for an average of 100 days, with an average of 1.5 admissions into palliative care beds; and each admission lasting for about 15 days. Third, regular territory-wide audits to ensure quality care. Fourth, professional and training development in specialized palliative care. Professional bodies of Hong Kong Society of Palliative Medicine and Hong Kong Hospice Nurses' Association were established in 1997. Palliative medicine became an accredited specialty for doctors in 1998 (Sham, Chan, Tse, and Lo 2006).

How do all these place Hong Kong in the world map of palliative care development? The International Observatory on End of Life Care is a body which monitors the palliative care development in over 200 places of the world. Palliative care development is assessed (Clark and Wright 2007) and these countries or places are categorized as follows: (1) no known activities — 78 places; 2) capacity building — 41; (3) localized provision — 80; and the most developed category of (4) approaching integration — 35 places. In the category of approaching integration, activities should include the following on top of the capacity building and localized activities: presence of critical mass of activists countrywide; a range of providers and service types; broad awareness of palliative care; measure of integration with mainstream service providers; impact on policy; established education centres; academic links; research undertaken, and presence of a national association. Hong Kong is among one of the 35 places with development belonging to category 4.

Is Palliative Care Making a Difference to Cancer Deaths in Hong Kong?

Information on our patients' deaths is valuable for us to evaluate the existing service delivery and to identify the strengths and the gaps. This should also be the concern and interest of professionals who have dedicated their career to care for the dying. A local study was undertaken by palliative care specialists in four local HA hospitals to evaluate the profile of cancer deaths in 2005 (Tse, Chan, Lam, Lau and Lam 2007). The hospitals under study have a specialist-led palliative care unit attached, and three of them have a 24-hour accident and emergency service. A total of 494 cancer deaths were chosen for retrospective analysis of their utilization of public health care in their last 6 months of life and their end-of-life process within the last two weeks of life. The mean age of all cancer patients was 72.6 years (SD 12.6). It was also found that the coverage of palliative care service was up to 66% of the total, but only 50% of the total died in palliative care setting. Therefore, in this cohort, half of the cancer deaths occurred in palliative care wards, and half in the acute care or non-palliative care settings. Cancer deaths who received palliative care and died in palliative care setting (PCS-PCD group, $n = 247$) had significantly fewer admissions to acute wards ($p = 0.012$), shorter duration of stay in acute wards ($p = 0.003$), and fewer admissions to ICU settings ($p < 0.001$) as compared with the other 2 groups of cancer deaths, namely those who received palliative care but died in non-palliative care setting (PCS-NPCD group, $n = 86$) and those who never received palliative care and died in non palliative care setting (NPCS-NPCD group, $n = 161$).

Within the last two weeks of life, patients in the PCS-PCD group had less invasive interventions initiated ($p < 0.001$); including insertion of nasogastric tube, Foley's catheter, intravenous infusions, blood transfusion, antibiotics, endoscopy, computerized tomography, assisted ventilation and surgery.

At the EOL, symptoms that were most commonly documented include: pain (56.3% of patients), dyspnoea (52.2%), fatigue (46.2%), anorexia (41.7%), oedema (36.4%), bowel problem (34.0%), cachexia (26.7%), oral problem (25.5%), nausea and vomiting (24.7%), and confusion (23.9%).

Patients in the PCS-PCD group were more likely to receive analgesics ($p < 0.001$), strong opioids ($p < 0.001$), adjuvant analgesics ($p < 0.001$) and sedatives ($p < 0.001$). Patients who died in non palliative care settings usually received weak opioids instead of strong opioids. However, even with more patients on strong opioids and sedatives, patients in PCS-PCD group were mentally more alert at 72 hours before death ($p < 0.001$), though physically more dependent in the last two weeks of life ($p < 0.001$). The results help to evade the myth that use of opioids will cause undue sedation or suppression of conscious level in cancer patients.

Overall, 94.7% of this cohort had DNR documented and 4.5% had CPR performed. None of the patients had CPR performed in the presence of DNR order. Patients who never receive palliative care (NPCS-NPCD group) had less DNR orders in place ($p < 0.001$) and more CPR performed ($p < 0.001$).

The place of death was not associated with the mean age of patient in this study. The average duration of the death episode was 16.9 days for all patients. In other words, most patients spent their last two weeks of life in hospital instead of at home.

While the results from this study suggested that palliative care service has played a role in improving end-of-life cancer care in Hong Kong, they also reminded us of the gaps in service. Among those patients who received palliative care in this cohort, 30% was referred within the last two weeks of life. Some of these late referrals ended up in a transferal to palliative care ward to die, but more received support from the palliative care consultative team while dying in the acute setting.

Dying in the Acute Setting

Though the above local study showed that 50% of cancer deaths in the four study sites died in palliative care beds, that percentage was lower when reviewing the overall cancer deaths in Hospital Authority in 2005. From the statistics provided by Hospital Authority, 10,174 cancer deaths occurred in HA hospitals in 2005. Among them, 32.3% died in palliative care units, 50% died in acute settings including intensive care, while the rest died in sub-acute or chronic care settings.

In simpler terms, one in every two cancer deaths occurred in acute care settings, one in every three cancer deaths occurred in palliative care settings, while one in 50 cancer deaths occurred in intensive care units.

However, multiple barriers to good EOL care in the acute setting may exist. In a qualitative study on nurses experienced in caring for cancer patients, the following were identified as difficulties in engaging in quality EOL care in the acute hospital setting: staff preoccupation with treatment and ward routine, negative perception of palliative care, inability to recognize the critical juncture to EOL state, intrinsic difficulty in prediction of prognosis, and perceived difficulty in engaging in emotionally challenging work of discussing withholding or withdrawing life sustaining treatment (Willard and Luker 2006). Health care professionals may feel more comfortable in continuing what is regarded as the usual type of care in the acute setting. Similarly, in a local acute hospital where on average four deaths occur in the acute setting per day, results from a questionnaire survey on 169 nurses and 20 doctors revealed considerable difficulties encountered in handling the scene of death. (Tse, Wu, Suen, Ko and Yung 2006). When encountering the death of a patient, one-third of staff in the study would not be confident and one-third would not take the initiative when managing relatives' emotions. The reported confidence of respondents did not agree with their ability to take the initiative as well. Nurses who perceived themselves as having no confidence would proceed to manage relatives' emotions. Non-acceptance of relatives about a patient's death and strong emotions were reported to be most difficult to manage. Relatives were perceived by staff to have the greatest concern over the effort of the health care workers in "saving" the patient. Inadequacies of staff, a busy and open working environment full of other patients, the apparent gaps between expectations for the end-of-life stage of the families and of the health care workers, together with the families' mistrust of them, have seemingly created great tensions surrounding death and dying in hospital. There is a call for enhancing the knowledge and skills of doctors and nurses in supporting the families in the scene of death.

To the family members, the scene of death means the moment of separation from their loved one. It will not be possible for us to remember each and every one of the patients who died, but surely, the scene of death of each person is unique and unforgettable to their family members.

Case 3: Death of my daughter

Mdm Ho was a 64-year-old widow whose daughter, Amy, suffered from chronic renal failure at a young age. With much struggling, her daughter received a kidney transplant which brought new hope to them. A year later, at the age of 28, *Amy was diagnosed to have incurable cancer of the colon. Devastated, Mdm Ho still hoped a miracle would occur. However, her daughter's health went relentlessly downhill and she died within a year of diagnosis of cancer.*

Mdm Ho recalled the day when she received the phone call from a nurse in the ward, informing her of Amy's critical condition: "I was absolutely confused, and I rushed to the hospital in the fastest way I could. I saw my daughter lying there, and I asked her to wake up and not to leave me alone. It was chaotic, and I kept on shaking her body. I didn't even know what I was saying. The nurse was so good. She held me in her arms. She was trying to comfort me even though I was in such a crazy state ... At the end, she suggested that I help clean my daughter's body. That is the greatest consolation to me on looking back. I know I was out of control that day, but after all, it was the death of my dear daughter. What can you expect me to do?

I did not remember the name of the nurse who helped me, but I would like to let her know how much she had done for me."

A hospital is never like home. Rules and regulations, routines, and lack of privacy contribute to depersonalization of death and dying. Dying in hospital also implies a good chance that family may not be around at the moment of death. This is especially true in the post-SARS era, where visiting policies and infection control measures are tightened.

Even when facing such intrinsic limitations in the acute setting, it does not require scientific expertise to help the family facing the trauma and agony of losing a loved one at the moment of death. Someone who steps forward and acknowledging that emotions are legitimate can make a difference then and after, as in the case of Mdm Ho.

Patient, Family and Home

There is no place like home. This is naturally more so when one expects only a limited time to live. Many people have the misconception that palliative care unit is a place where they would stay and wait for death to come. On the contrary, patients stay in local palliative care units for an average duration of around 15 days. They are facilitated to return home when acute symptoms are being controlled. Nonetheless, advanced cancer patients at home do have multiple needs, as illustrated by the profile of a cohort of 130 palliative care patients who received home-care service locally (Tse 2007a) (Table 10.2).

Family caregivers play an important role in this journey. In palliative care, patient and family members are served as a unit, but family members are also

(Data from 130 home-care patients in Caritas Medical Centre in 2003)

Mean age	69 yrs (36–90)
Mean PPS	60 (30–90)
Living alone	10%
Old age home	20%
Living with family	70%
Problems recorded:	
Pain	72%
Edema and lymphedema	59%
Oral problems	52%
Constipation	42%
Dyspnoea	32%
Nausea and vomiting	28%
Wounds / drains	23%
Devices	13%
Ryle's tube	5%
Foley	4%
Ostomy	3%

PPS = Palliative Performance Scale
PPS 60 =
1. Reduced ambulation
2. Unable to perform housework
3. Needs assistance in self care
4. Normal or reduced intake
5. Conscious or confused

Fig. 10.2 Profile of palliative home-care patients with advanced cancer

crucial in providing support and care for patients at home. When patient is not communicable, the family can act as the proxy or surrogate for reporting symptoms and making medical decisions. A family member, therefore, is a caregiver and a care receiver. A family member can also be a facilitator or a barrier during the care process.

Family members are vulnerable to negative outcomes in physical and emotional well-being in view of the demanding tasks of caregiving. Loke, Liu and Szeto (2003) reported that local caregivers of advanced cancer patients were facing major difficulties at home, including managing the relationship with the patient, coping the emotional reactions of the patient, meeting the physical demands in caregiving and bearing with the restrictions in social life.

Another local study (Chan and Chang 1999) investigated the relationships between perceived difficulty in managing caregiver tasks and the experience of stress symptoms among 26 family caregivers of terminally ill patients with cancer in Hong Kong. Caregivers who experienced more stress symptoms had reported increased difficulty in managing caregiver tasks ($rs = 0.64$; $p < 0.001$). Caregivers were also overwhelmed by psychological stress symptoms, rather than physical symptoms. They often felt tired, worrisome and irritable. In addition, caregivers who had less education were at higher risk of developing stress ($p < 0.01$).

Case 4: A couple in despair

Mr Wong was a 60-year old gentleman who was diagnosed to have carcinoma of the pharynx in 2000 and he underwent a surgical removal and radiotherapy. In December 2000, recurrence of tumour in his tongue was found and he underwent another surgery to remove most of his tongue. In March 2002, another tumour growth was found in the floor of his mouth, and the third surgery was performed, with the floor reconstructed with the muscle flaps from his chest and axilla. Unfortunately in September 2002, further local recurrence in the oral cavity was detected, requiring another excision. Not long after this surgery, in December 2002, he was diagnosed to have a lung tumour. By then, Mr. Wong was referred to our palliative care clinic as patient did not want any further surgery, chemotherapy or radiotherapy.

On first consultation, Mr Wong appeared very withdrawn and in a very low mood. He was obviously wasted and had a hole permanently created in his throat for breathing and phonation. His outer facial appearance was relatively well preserved, but functionally, he expressed difficulty in swallowing, talking, sleeping and looking after himself.

His wife, who accompanied the patient during the visit, was totally worn out. Apart from taking care of patient at home, she also had to take care of three children, the household chores, the finance management, and all the tasks related to medical care of the patient. She also called herself an emotional outlet for the patient, who was in constant frustration. The distress of Mrs Wong came from witnessing the suffering of patient and sense of losing control as adverse events appear one after the other. Although a caring and responsible wife, Mrs Wong was so overwhelmed that she would prefer her husband to die sooner.

Illness is a family matter. While the patient suffers, the family members also undergo a painful journey, which will continue as they grieve after patient's death. The dying journey is then one of saying goodbye to possessions, achievements, and relationships with the loved ones. While patients are facing the pain and suffering as the diseases progress, the caregivers are continuously adjusting to the burden of care giving.

The importance of the palliative home-care service cannot be over-emphasized in this difficult journey. It facilitates continuity of care after patient's discharge from hospital, and supports patients to stay at home for as long as possible. In delivering a home visit, the palliative home-care service will perform assessment of the patient and family and provide on-site intervention and appropriate bridging and referral if necessary. Data from 141 home-care patients under the palliative care of Haven of Hope Hospital (Tse 2007a) revealed the list of home interventions as follows: symptom management (98%), drug supervision (86%), health system facilitation (93%), psychosocial spiritual support (77%), caregiver education (58%), coping empowerment (40%), bridging community resources (38%), nursing procedures (28%), management of equipment and aids (24%), and grief work (15%).

A local study showed that home-care nurses could empower patients and caregivers at home (Chan and Cheng 1999). Family members reported empowerment by home-care nurses through their engaging by commitment, involvement, accessibility; providing information, knowledge and skills; affirming self-worth; and reassuring that the patient is receiving good care from caregivers. Home-care nurses were also perceived by caregivers as significantly more helpful than family or friends (Loke et al. 2003; Yan and Kin-Fong 2006; Mok, Chan, Chan, and Yeung 2002; Mok, Martinson, and Wong 2004).

Although home is a better place to stay for most patients, this preference may become more unrealistic or difficult to achieve in our contemporary society. Hong Kong is place of low birth rate and long life expectancy. There is a tendency for smaller households and more people are living alone. There is rising proportion of women in the labour force, who are expected to be natural caregivers of patients (Holroyd and Machenize 1995; Holroyd 1993). Even if family members are present, their long working hours may leave patient alone at home for most time of the day. Intrusion into space, time, life-style and personal goals of family members may be less well tolerated, with change in social milieu and culture. This is especially so when caregiving at home is not being valued or recognized.

The palliative care team can provide considerable professional support, but a supporting community network is also required to meet the diverse needs of patients and their family members. We have less supportive neighbourhoods nowadays, and the family doctor system is not yet firmly and widely established.

As patients deteriorate clinically, they will be admitted to hospital to die. Home death is rare in Hong Kong. According to one local review of 1,300 advanced cancer patients under palliative care from 1999 to 2003, only six of them died at home (Liu 2006). These home deaths did not occur by chance. The common features of the caregivers of the six patients were: female, young and educated; available 24 hours a day; lived with family in a spacious home; had good and stable financial status; received good support from family members; and had access to support network. In addition to this background, they also had access to professionals with knowledge, skill, experience, confidence in EOL care, who were prepared to pay regular visits and were available when needed.

Although dying at home may not be preferred by some patients or families, it is important that home death is an option when so desired. From where we are now, home death is still a dream too far to reach in Hong Kong.

Death: From a Personal Journey to a Social Issue

Preparing for death is not a just a cognitive process, but one begins with death awareness and hopefully ending in acceptance, transcendence and closure. For many patients with terminal illness, it is the time for them to slow down physically, but this is also the time when their minds take up the greatest momentum in life — a time for recollection, a time for reflection, a time for reconciliation.

A good death is a consolation not just for the dying, but also for the living. Death of a person inevitably affects many others who are connected, not to mention the close family members. In a qualitative study on the grief of widows (Chow, Chan, Ho, Tse, Suen, Yuen 2006), their experiences in the final days in a palliative care unit were frequently recalled as they talked about their relationship with their husbands. What helped before death of patients included being given time to accept and to prepare for death; creating fond memories and legacies, e.g., photos; keeping the patient in a clean and tidy condition; being given opportunities to provide care for the patient; and the supportive environment of the palliative care unit. What these widows found helpful at the moment of death were their being present with the patient, the patient looking peaceful when dying, and their emotional containment at moment of death so that patient can die in peace. After death of their husbands, the widows experienced ongoing relationship with the deceased through talking to the photo of the deceased, feeling the presence of the deceased, and continuation of the deceased's familial responsibilities and obligations. These findings show how a painful event could be transcended into a memorable and meaningful experience for the bereaved.

However, with death and dying alienated from the public and the community, we need more than just the published studies to break the barrier and to improve awareness. Myths, misconceptions and taboos among the public add further to aversion and hesitation in open discussion about this universal and natural event of life. Death and dying appears in media as medical failures or suspected negligence.

Hong Kong is a place where East meets West, where we are exposed to both Chinese traditional and Western cultures. Though modernized in many ways, Hong Kong is still way behind in life and death education, in cultivating a milieu for discussion of death and dying and of advance care planning in preparation for the end of life. Withholding and withdrawal of life-sustaining treatments at the end of life is often confused with euthanasia in public discussions and in the mass media.

As a palliative care physician, I often encounter patients who would like to die earlier. Some have so much pain that they would rather die; some feel too guilty to burden their families; some feel that they have lived long enough; some feel that they are well prepared; some are afraid that the doctor will try all means to extend life; and some just want us to listen and demonstrate that we do care.

Most of them, even if they stated "euthanasia" as a wish, are not referring to "the direct killing by the physician upon patient's request". Mak and Elwyn (2005) reported in a local exploratory study that the desire of patients who requested euthanasia was not confined to physical or psychosocial concerns relating to advanced cancer, but incorporated hidden existential yearnings for connectedness, care and respect, as understood within the context of the patients' lived experience. Patients were anticipating or fantasizing a painful dying process worse than death itself.

Setting the Scene for the Future

Care for the dying is not just a family matter, or just a part of the medical care, but also a matter that concerns the society by large. Palliative care physicians should be advocates for quality palliative and end-of-life care for patients who are facing life threatening illnesses. A decade after the establishment of palliative medicine as a subspecialty in Hong Kong, a position paper of the Hong Kong College of Physicians was published (Tse 2009a). The paper outlines the challenges that we are facing with aging population and increasing prevalence of multiple chronic diseases in Hong Kong, and the gaps that we need to address in the healthcare system to meet the evolving needs. It is imperative that palliative care for non-cancer diseases, which is long due, should be developed now. Yong et al. (2009) reported that local patients with end-stage renal disease had significant symptom distress and impaired quality of life. Driven by patients' needs, a local model of renal palliative care is developed as an option for those who prefer palliative care and those who are at poor risk for dialysis (Tse, 2009b). Further studies on palliative care for other non-cancer diseases are urgently needed to shape the way forward.

Developed countries have come to realize that care for the dying should be driven by government policy. Hong Kong is a place of lowest infant mortality, and a place of long life expectancy. We have done an excellent job to offer the babies a safe and warm welcome to this place; we have been trying hard to achieve healthy living, but we certainly need more commitment before we call Hong Kong a place for good dying.

Note

1. As palliative care workers, the encounters with our patients teach us not so much about how to die, but more importantly how to live even when the end is expected to be near. It is the present where we live, not the past, not the future. Ming was among the many patients that

we had encountered in their last journeys, but unexpectedly, Ming was also among the few patients who had encountered the last journey of his home care nurse, Michelle. Michelle, young and diligent, had been supporting Ming with great sensitivity: from the most practical gestures of bringing him domestic utensils to the spiritual care in restoring Ming's dignity and wholeness as a person despite his disfigurement. On the morning of 23 May 2007, Michelle called Ming by phone to send some warm reminders. On the same day at noon, Michelle was tragically killed in a road traffic accident on her way back to the hospital after visiting her patients.

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Part V

Mass Trauma and Disaster

The severe natural disaster has cost us a lot. Now we are at the crucial stage of fighting the quake and continuing disaster relief. We need to be calm, confident and united to achieve success. Our top priority is saving lives and rescuing those trapped …
– Wen Jiabao, 1942– (14 May 2008)

11

Psychological Support for the Community After Disasters:

A Review of the Development in Hong Kong

Helios K. C. Lau

What Have We Learned After 9/11?

After the infamous attack on the World Trade Center in 2002, Mr. Giuliani, the then Mayor of New York City, said he was glad that the attack took place in New York City because it was probably the city in the world that was most prepared for this. Whether this was true was another story but what he said prompted me to ask the question, "Are we ready?"

Many will join me to say, with their fingers crossed, of course, that Hong Kong is a "blessed place" (福地). In a place this small, packed with close to 7 million people, any disaster, man-made or natural, could have catastrophic ramifications. We have been lucky so far that disasters we went through did not claim more lives than they had. However, we all know that we cannot rely on luck forever.

A couple of years ago, clinicians in Hong Kong were quite apprehensive of the potential outbreak of the Avian Influenza pandemic. The vigilance and alertness of the community had lowered in general when later on the "promised strike" did not come. Yet, can we afford to be complacent? Can local mental health professionals honestly say that Hong Kong is ready for the next big disaster? In this chapter, I shall review the development of the post-disaster psychological support for the community in Hong Kong and discuss issues that I hope will stimulate some serious thinking and maybe even an answer to this question.

Psychological Services for the Community After Disasters — A Brief Overview

Disasters and disaster management are as old as the human history itself. From the Noah's Ark in the Bible to the Chinese folklore which told of Huan Jing's

(桓景) retreat to the hills with his family to avoid the plague, we see that disaster struck all the time and people were trying to manage it, one way or another. We would have thought that with the advance in science and technology, the world is now safer than it was before. However, this is not the case. Some statistics show that actually in the contemporary world, not only are there more disasters, whether natural or technological, but the aftermath of the disasters have been growing progressively more serious in terms of the number of people affected and their cost. Worldwide, the number of disasters is actually increasing each year. Extreme climatic changes and increased human settlement in more vulnerable places are two primary explanations for the increase in annual disasters (Coppola 2007).

Despite the fact that disasters are increasing in numbers throughout the years, it was not until the 1990 genocide in Rwanda and ethnic cleansing in the Balkan wars that nations of the world turned their attention to the fact that some concerted efforts were needed to help disaster victims. The United Nations (UN) declared the 1990s to be the International Decade for Natural Disaster Reduction (IDNDR). On 22 December 1989, the General Assembly of the UN passed a resolution to set goals that the participating nations are to achieve during the IDNDR. These are to:

1. Improve each country's capacity to mitigate the effects of natural disasters expeditiously and effectively, paying special attention to assisting developing countries in the assessment of disaster damage potential and in the establishment of early earning systems and disaster-resistant structures when and where needed.
2. Devise appropriate guidelines and strategies for applying existing scientific and technical knowledge, taking into account the cultural and economic diversity among nations.
3. Foster scientific and engineering endeavours aimed at closing critical gaps in knowledge in order to reduce loss of life and property.
4. Disseminate existing and new technical information related to measures for the assessment, prediction, and mitigation of natural disasters.
5. Develop measures for the assessment, prediction, prevention, and mitigation of natural disasters through programs of technical assistance and technology transfer, demonstration projects, and education and training, tailored to specific disasters and locations, and to evaluate the effectiveness of those programs (United Nations 1989).

There are four key features in the international disaster management scene: mitigation, preparedness, response and recovery (Coppola 2007). Mitigation refers to the reduction or elimination of the likelihood of disasters. Preparedness refers to readiness of people to cope with the disaster and their chance of survival. Response means actions to reduce or eliminate the impact after the disaster.

Recovery is about rebuilding and returning victims to the normal state of life. These themes should guide nations and policymakers in preparing their disaster management plans. They are equally applicable to planning of psychological services for communities after disasters nowadays.

As we can see from the UN resolution, while advances have been made in international disaster management in the past decade, there has been little or no reference to post-disaster psychological support. The emphasis is still on saving of lives, replacement of damaged property, and restoration of the economy. Behind this is perhaps the still unresolved conflict among mental health professionals regarding when or if psychological support services should be provided.

There are two extreme positions. Some would say that it is meaningless to provide psychological support services when people are still salvaging what they can from the ruins of a disaster. When people are still under potential threat to their physical security, it does not make sense to stop them and ask them to attend to their psychological needs. Holders of such a view are not wrong if we were to believe the needs hierarchy postulated by Abraham Maslow. This position is perhaps best exemplified in the article "The Therapy Reflex" written by Sally Satel, a psychiatrist in the United States, in response to the tsunami in 2004:

> To many mental-health workers the tsunami is a time for action. So much trauma, so little time, is the mindset. They should talk to someone themselves — a Sri Lankan psychiatrist called Ganesan. He is the only psychiatrist for the country's entire eastern population of 1.3 million. Since the giant waves hit, Ganesan (who goes only by one name as is customary in his country) has been coordinating foreign aid, distributing medicine to children, and transporting corpses in his pick-up truck. What he doesn't do is therapy. "To talk about psychological needs when you've got thousands of people using one toilet in a refugee camp — it's absurd," Dr. Ganesan, 41, told a *Washington Post* reporter. He is right. The main issue at this stage is to ensure the physical safety, locate missing friends and family members, and disseminate accurate information. Schools opened on January 10, the end of the country's annual holiday. More than any therapy this will promote effective coping by maintaining routines for children and keeping them busy … In short, the prescription is this: minimize disorder and plan for the future — and for the vast majority, coping will follow naturally. (Satel 2005, p. 1)

Our experience in Hong Kong lends support to this position. We have learned that whatever psychological support services we may want to introduce, we will often have to wait until the victims have taken care of the practical aftermath of a disaster. Otherwise, they will simply decline the offer of psychological interventions. This is reflective of the natural need for self-protection of the victims by turning their attention to other practical and less emotionally disturbing matters. Who are we to argue that they should not?

Advocates at the other extreme, however, argue fervently for the advantages of bringing in psychological first aid as early as possible to mitigate the emotional impact of the disaster and to prevent development of a myriad of psychological or psychiatric disorders that would cost the afflicted communities even more in the long run. An example of this position is the press release from the International Federation of Red Cross and Red Crescent Societies (IFRC) in April 2001:

> Victims of disasters need immediate emotional and psychological support said the International Federation of Red Cross and Red Crescent Societies, marking the World Health day on 7 April, which this year focuses on mental health. Psychological wounds may be less visible than material losses such as the destruction of homes, but they often take far longer to heal.
>
> Experience shows that psychological needs permeate and affect all other aspects of relief such as shelter, food and basic health care.
>
> "Neglecting emotional reaction may result in passive victims rather than active survivors, but early and adequate psychological support can prevent distress and suffering from developing into something more severe and will help the people affected cope better and return more rapidly to normal life," said Federation President Dr Astrid N. Heiberg, herself a psychiatrist, at the launch. "Our ambition should be to heal not only the wound, but also the wounded." (IFRC 2001, p. 1)

Local experiences show that the two positions are not mutually exclusive. Whether either position is accepted by a community will depend on cultural factors as well as the degree of "psychological sophistication" of the community. As clinicians, we have perhaps all witnessed the agonies that some victims go through after disasters. On the other hand, we have also seen people who survive the trauma and recover by themselves. In the present state of affairs, we have but a limited understanding of what may constitute effective treatment or prevention. Therefore, it is only fair to adopt a cautious and flexible attitude. The key is the sensitivity to the real needs expressed by the victims and the humility to respect the culture of the population affected.

If we delve deeper into the question, it is not difficult to see that behind the surface controversies, there is a more fundamental disagreement on who to give what to whom and when. The crisis responders and helping professionals who rushed to the scene to offer help after the 2004 tsunami were teased by some as "trauma tourists" or "ambulance chasers". Similarly, some described the pouring in of foreign aid, including the influx of different psychological interventions, as attempts to impose Western ideologies on the predominantly East Asian victims.

Gerard Jacobs warned that "Care for traumatic stress can't be delivered by Western experts parachuting into affected cultures without an appreciation of the cultures infused with strong Islamic, Hindu, and Buddhist beliefs" (Stout 2006, p. ix). Who is to say that the indigenous inhabitants along the South Pacific shores are in need of, and can benefit from Western crisis intervention?

To some, the question is whether we need to do anything at all for the disaster victims. In discussing the "short-term and long-term psychological impact of disasters", the authors referred to "disaster myths" and queried whether the "severe emotional disturbances" were over-emphasized by certain service promoters and the mass media. They argued that because of methodological difficulty, there was a general lack of vigorously designed research that can scientifically support the claim that disasters result in higher rates of psychopathology afterwards. It is important, therefore, for service provider to re-think what they are offering to the disaster victims lest they would be interrupting the natural recovery of the victims. It is natural that disasters have very strong emotional impact but the majority of the victims have ways to cope. Only a small percentage of the victims will require subsequent mental health treatment. Therefore, they proposed that perhaps what mental professionals should do is to facilitate the victims through this natural recovery process: "for example, becoming sources of information to victims by familiarizing themselves with local and national, public and private financial resources, and helping to create formal and informal settings where help can be requested and provided" (Salzer and Bickman 1999, p. 77).

Who is right or wrong? What is right or wrong? It may take years and many more debates before we have the ultimate answer. Before the answer is available, we have to agree that in times of a massive disaster, we must put aside our differences, forget the issue of who the authority should be, and work collaboratively towards the goal of bringing in what is best for those afflicted by the aftermath of disaster after reviewing the relevant scientific evidences at the time and allowing for adaptations to meet the specific needs due to the different nature of disasters and where they take place.

The history of providing psychological support to victims of mass disasters can be traced back to the early initiatives of providing crisis intervention, since crisis intervention and its major principles are the backbone of psychological support services for disaster.

Mitchell and Everly (1997) described two distinct epochs or periods in the development of crisis intervention. The first period was dated back to the World War I when there was initial evidence to show that early intervention could reduce chronic psychiatric morbidity. In the 1960s and 70s, the British psychiatrist Gerald Caplan started the movement of preventive psychiatry to reduce the long term in-patient psychiatric treatment. This remains, until today, one of the goals in post-disaster psychological services.

According to Mitchell and Everly (1997), the primary advances in this first period were the development of community crisis intervention. The shift was to emphasize on brief intervention, on counselling and problem solving techniques, and on use of non-medical personnel. The goal in this period was in prevention and in deinstitutionalization.

Marking the beginning of the second period was the formal inclusion of posttraumatic stress disorder (PTSD) in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) (American Psychiatric Association 1980) and the beginning of a whole host of initiatives to prevent it in the wake of disasters. One of such initiatives was the establishment of the International Critical Incident Stress Foundation (ICISF) in 1989. ICISF promoted Critical Incident Stress Management (CISM) as a standard protocol and a systemic approach with the clear aim of providing crisis intervention by mitigating the impact of disasters and preventing symptoms from deteriorating into severe and chronic psychiatric disorders. According to Mitchell and Everly, the founders of ICISF, the specific goals of the CISM programme are to reduce the incident, duration, severity of or impairment from traumatic stress resulting from crisis situations, and to facilitate in-depth or continued mental health interventions when necessary (Mitchell and Everly 1997).

At the heart of the ICISF model are the basic concepts of Gerald Caplan's preventive psychiatry which emphasize the three levels of intervention: primary, secondary and tertiary. As defined by Mitchell and Everly (1997), CISM is "an integrated and comprehensive multi-component programmatic approach to the prevention and mitigation of crisis states and subsequent critical incident (traumatic) stress" (Mitchell and Everly 1997, p. 11). They defined critical incident as an event which "has the potential to overwhelm one's usual coping mechanisms resulting in psychological distress and an impairment of normal adaptive functioning" (Mitchell and Everly 1997, p. 11). Although the word "disaster" is not used in their formulation, it is clear when one looks at the definition of "disaster" in the disaster psychology literature that the meanings of the two terms "disaster" and "critical incidents" are very similar. The UN define an international disaster as "a serious disruption of the functioning of society, causing widespread human, material, or environmental losses which exceed the ability of the affected society to cope using only its own resources" (UN 1992, p. 28). In both definitions the emphasis is on failure to cope and disruption of normal functioning. Hence, it is reasonable to say that principles for managing critical incidents are applicable to disaster management. In actuality, CISM has been applied to cover entire communities devastated by natural disaster.

Started out as a model designed for use by emergency personnel in critical incidents, the ICISF model soon evolved into one of the world's largest standardized crisis response network and finds its application in disaster management both in the US and worldwide. The ICISF model was widely adopted by national and state agencies in the United States including various law enforcement agencies such as the Federal Bureau of Investigation (FBI), the US Marshals' Service, US Coast Guard, US Secret Service, as well as local fire services and hospitals, among many others. Outside the United States, the ICISF model was also adopted by the Australian Navy and it is the basic model adopted by the Hospital Authority, the Hong Kong Police Force, the Education Bureau and Social Welfare Department of Hong Kong SAR Government in their systems of providing psychological support services to those affected by critical incidents or disasters.

In 1992, the American Red Cross (ARC) started a nationwide disaster management network. The ARC model is also a multi-component model which resembles CISM in its recognition of mental health interventions like psychological first aid. As the ARC is a prestigious international agency in the management of disasters, the ARC model has established a very important role in the world scene. Today, the IFRC has a series of comprehensive psychological support programmes (PSP) which are integrated with the organization's various disaster management programmes all over the world.

As in other fields of mental health interventions, there have been incessant disputes over what works and what does not. The same phenomenon is noted in the field of disaster management. Apart from the priority and timing in the provision of psychological intervention mentioned before, there were controversies over what intervention model to apply. One very good example in the past decade is the attack on Psychological Debriefing (PD) notably by psychiatrists from the United Kingdom. Advocators on both sides cited their own evidence, some research-based, some rather subjective, to defend their positions. The debates are unsettling for policymakers and administrators because doubts are cast on the methods that they are implementing or intend to develop and they are not told what the right directions are. However, a careful review of some of the criticisms may show that they may not be based on objective evidence or accurate facts. It is a pity that in the field of disaster management, the need to fight for recognition and hence resources may often mask the real important issue of agreeing on what to do best for the disaster victims, be it CISM or other models.

In the development of psychological services in response to disasters, the consensus is more important than the differences. If we have learned anything at all over the past years, we will have to accept that standardized care is of the utmost importance. In the chaotic hours after a disaster, it is important for helpers and the governments or organizations orchestrating support services to agree on what to do and when. They should speak a similar, if not an identical, language to ensure that the same kind of help is given anywhere, and the same victims can expect to be followed up by compatible interventions wherever they may be.

An early attempt at reaching consensus was by the Subcommittee on Early Psychological Intervention of the National Voluntary Organizations Active in Disaster (NVOAD) in the United States. Drawing together experts from the American Red Cross (ARC), International Critical Incident Stress Foundation (ICISF), National Organization for Victim Assistance (NOVA), and the Salvation Army, the NVOAD discussed and endorsed, at its annual conference in 2005, the "Early Psychological Intervention Points of Consensus Document". The main points of consensus in this document are:

1. Early Psychological Intervention (EPI) is valued;
2. EPI is a multi-component system to meet the needs of those impacted;
3. Specialized training in EPI is necessary;
4. EPI is one point on a continuum of psychological care. This spectrum ranges from pre-incident preparedness to post-incident psychotherapy, when needed;
5. Cooperation, communication, coordination and collaboration are essential to the delivery of EPI.

The consensus is a compromise of a kind that seeks to circumvent the debate on what types of specific interventions are useful. It emphasizes the basic principles or philosophies and allows flexibility in the development of specific strategies. This is perhaps the most sensible and pragmatic approach to solve the problem. In the document, the key words are "multi-component" and "training". A comprehensive approach to disaster psychology must address the preventive elements. This is true of other aspects of disaster management apart from psychological support. A community has to be psychologically prepared and the systems in a community have to be designed in ways to minimize potentially negative psychological impacts when disasters strike. It is important that members of a community have good general mental health and knowledge. There should be psychological treatment and support networks ready to be put to action. There should be adequate support at all levels, from crisis intervention to long term in-patient psychiatric treatment, and from individual care to treatment for specific groups or the community at large. There should be sufficient trained personnel as well as trained volunteers who can help out. These are ways to ensure that a community is ready for the strike of a disaster.

Apart from the NVOAD consensus, another important effort to arrive at consensus was by the National Institute of Mental Health (NIMH) in the United States in 2001. The NIMH hosted a workshop to address the impact of early psychological intervention and to identify what works or does not work, and what the gaps are in our knowledge. Fifty-eight disaster mental health experts from six countries participated in the workshop. A report was subsequently published listing out points that the experts agreed on, dissenting views, and areas for further research (NIMH 2002) The participants of this workshop examined research on critical issues related to the following questions:

1. What early interventions can be recommended in mass violence situations?
2. What should the key operating principles be?
3. What are the issues of timing of early intervention?
4. What is appropriate screening?
5. What is appropriate follow-up, for whom, over what period of time?
6. What expertise, skills, and training are necessary for early interventions, at what level of sophistication?
7. What is the role of research and evaluation?
8. What are the ethical issues involved in early interventions?
9. What are the key questions for the field of early intervention that have not yet been thoroughly researched?

There was general consensus among participants on many points. These included:

1. The importance of early psychological intervention (which in the report refers to any form of psychological intervention provided within the first four weeks following mass violence or disasters) is confirmed. Preparation, planning, education, training, and service provision evaluation are listed as key components in EPI. Early mental health assessment and intervention should focus on a hierarchy of needs, e.g., survival, safety, food, shelter, etc. and a sensible working principle in the immediate post-incident phase is to expect normal recovery. It is not appropriate to presume that there are clinically significant disorders at the early post-incident phase and participation in EPI should be voluntary.
2. There should be more vigorous research using randomized controlled trials (RCT) to evaluate effectiveness of interventions and to establish best practice. Existing studies with RCT are scarce but they do support that early, brief, and focused intervention can reduce distress in bereaved spouses, parents and children. There is evidence that selected cognitive behavioural approaches may help to reduce acute stress disorder, posttraumatic stress disorder, and depression in survivors. Single one-on-one recital of events and emotions evoked by a traumatic event do not consistently reduce risks of later posttraumatic stress disorder or related adjustment difficulties. There is no evidence that eye movement desensitization and reprocessing (EMDR) as an early mental health intervention, following mass violence and disasters, is a treatment of choice over other approaches.
3. There may be different times for best effects of different intervention. However, the key considerations for timing of early interventions should be the needs of the survivors — how they accept the interventions and how the interventions are matched with other existing practices.

4. Follow-up should be provided for those presenting with acute stress disorder or other clinically significant trauma symptoms, the bereaved, those having preexisting psychiatric disorders, those who require medical or surgical attention and those whose exposure to the incident is particularly intense and of long duration.
5. Providers of mental health intervention should know their limits and make appropriate referrals when additional expertise is required. With interventions that have a high potential for unintended harm, professionals with high degree of training, expertise and accountability should be used.
6. Research and evaluation of EPI are of utmost importance. Findings should be used to help policy makers to make informed decisions. There should be education for policy makers as well as the general public to help them to understand the best use of early psychological interventions.

The NIMH and NVOAD documents share many common points and these are important considerations for the development of post-disaster intervention anywhere in the world.

Apart from the two attempts to reach consensus cited above, there was a third path to consensus in the international scene which was brought about by the promotion of the concept of Psychological First Aid (PFA) by different leading figures and organizations of the world such as the American Red Cross, the International Critical Incident Stress Foundations and the World Health Organization.

Psychological First Aid (PFA) is not a new concept. As early as the 1950s, the American Psychiatric Association has recognized the pattern of reactions to disasters and recommended that front-line mental health workers should be familiarized with such reactions and how the victims cope with them. PFA has been developed very rapidly at the turn of this century and receives significant attention in the field of disaster mental health. It is derived from the concept of physical first aid. The goal of physical first aid is to contain the injury, stabilize the victim and get him or her to proper treatment as soon as possible. The same applies to PFA. The goal is to mitigate the negative symptoms, to provide crisis intervention and follow-up treatment or other services as warranted.

Everly, Lanlieb and Kaminsky (2005) note that:

the goals of psychological first aid are to:

1. stabilize psychological and behavioral functioning through meeting basic physical needs, then addressing the most basic of psychological needs;
2. mitigate psychological distress and dysfunction;
3. achieve a return to acute adaptive psychological and behavioral functioning; and/or
4. facilitate access to continued care.

From a more tactical perspective, psychological first aid may be intended to achieve any of the following:

1. the provision of information/education;
2. comfort and support (i.e., intervention based upon providing soothing human contact is legitimate and can be universally applied);
3. an acceleration of recovery;
4. the promotion of mental health;
5. the facilitation of access to continued or escalated care.

While psychological first aid has yet to benefit from careful research and evaluation, we are hopeful that it may hold promise in the items enumerated above (Everly et al. 2005, pp. 5–6).

Elsewhere, Gilbert Reyes noted that Psychological First Aid "relies on self-evident activities that are likely to reduce the extraordinary stress felt by survivors without the need of professionally trained mental health workers. Humanitarian organizations have already begun to develop ways of incorporating PFA principles into the overall package of relief services they are prepared to provide. While there is no scientific evidence to support PFA as an effective intervention for the prevention of mental health problems, there is also no obvious reason to believe that these practices are in any way harmful (Reyes and Jacobs 2006, p. 11).

According to Reyes and Jacobs,

> the principles of PFA require providers to protect survivors from further psychological harm while supporting them through the course of their recovery. The basic goals of PFA include reducing physiological arousal, assisting with coping, and advocating for those who are unable to gain adequate access to resources or services. Community-level interventions are viewed as being more efficient, appropriate and sustainable. Persons affected by disasters are not seen as passive victims, but rather as active and resilient survivors who can ultimately take responsibility for their own recovery. These survivors are understood to be undergoing normal adaptive processes, rather than being mentally ill or traumatized. Practitioners of PFA are not necessarily mental health professionals, but instead may simply be competent local providers of culturally appropriate social support. More experienced practitioners can provide mentoring supervision for newer PFA providers, both helping to ensure adequate service quality and providing emotional and informational support to their less experienced coworkers. In the event that survivors require help that exceeds the competencies of a PFA practitioner, they should be routed to other services and possibly referred for professional mental health management. In recognition of the negative impact that cumulative occupational stress can have on PFA practitioners, the providers themselves

> are cautioned to take proper care of their own physical and psychological health, and humanitarian organizations are obligated to provide adequate support, leave and supervision for their PFA staff and volunteers. (Reyes and Jacobs 2006, p. 11)

The quote from Reyes and Jacobs above serves not only as a good summary of what PFA is, it also highlights the important aspects that should be attended to by service providers.

The success in the future development of psychological services in support of disaster victims lies in whether or not various service providers can unify the ideologies and standardize strategies that can guide the development of culturally specific intervention systems and protocols for individual communities. The principles of Psychological First Aid (PFA) or Early Psychological Intervention (EPI) provide the ideology while the model of CISM may provide one of the frameworks of intervention strategies. They fit well into the key components in international disaster management — mitigation, preparedness, response and recovery. With further development and modification, they may one day become the unified "language" we speak in planning and implementing psychological services in responses to disasters in the future. With this note, let us turn to the local scene of disaster management in Hong Kong.

Psychological Services for the Community After Disasters — The Local Scene

Considering the late start in the international scene, Hong Kong is not doing too badly today, bearing in mind the short history of development of psychology in Hong Kong. In the early years, psychology and mental health were practically unheard of by the community at large. Welfare assistance and material relief were the two only tasks undertaken by the Government and the then voluntary agencies (志願機構) to help victims of mainly natural disasters such as typhoons and landslides. The most notorious examples were Typhoon Wanda in 1962 and the landslides at Kotewall Road and Sau Mau Ping in 1972. Some may also remember the fire in Shek Kip Mei in the 1953 and the riots in 1967. These were times when no one paid any attention to the psychological reactions of the victims and their families, less to say the psychological intervention that they needed.

The first attempt to deal with people's psychological reactions to disasters could be traced back to the response to the student movement in Tiananmen Square (天安門事故) by a group of clinical psychologists of the Hong Kong Psychological Society (HKPS) in 1989. The incident stirred up strong emotions from the community. There were numerous reports of and enquiries on news reporters covering the story in Beijing who were afflicted with symptoms compatible with what we now would diagnose as posttraumatic stress disorder (PTSD). Some clinical psychologists of the HKPS got together and set up a telephone hotline which they manned on a voluntary basis. Announcements were made in some local newspapers calling for reporters and other members of the community affected to seek help. The effort was at best ignored. One newspaper columnist actually wrote an article to ridicule the psychologists in Hong Kong and teased them as over-reacting. We have learned a valuable lesson and realized that any intervention, no matter how well meant, will not receive its due recognition nor serve its function unless members of the public are educated about its usefulness and willing to accept it.

Many other disasters took place since then. There was the Lan Kwai Fong incident in 1993 in which 20 were trampled to death after the New Year's Eve countdown. A hill fire at the Pat Sin Range killed 3 students and 2 teachers in February 1996. In November of the same year, the blaze at the Garley Building in the heart of Kowloon claimed 40 lives. In January 1997, a fire at Top One Karaoke in Tsimshatsui killed 20 while another fire at Mei Foo Sun Chuen killed 9 in April. In 1999, a China Airlines plane flipped over during its landing at the new Hong Kong International Airport at Chek Lap Kok, but miraculously only 2 passengers were killed. Then there was the infamous SARS (Severe Acute Respiratory Syndrome) epidemic in 2003.

The incidents in the previous paragraph were cited because changes continued to take place in Hong Kong as these tragedies happened, in terms of how members of the community perceived such events and how they demanded a different genre of help. Changes were also observed and in terms of how the Government responded and reorganized its emergency responses afterwards. It is important to understand such changes and the factors behind them in order to understand the development of psychological support services in response to disasters in Hong Kong.

The first change to note is the increased coordination among government departments and the eventual compilation of comprehensive disaster/emergency response plans in the Government. With the advance in informational technology and the more widespread influence of electronic media, tragedies were covered more vividly and in greater detail. As a result more people are vicariously affected and aggrieved, demanding more from the Government when disaster strikes. This change was best exemplified by the blaze at the Garley Building in Mongkok in November of 1996. Apart from the record death toll of 40, the gruesome images of people burning to death that appeared on television news was disturbing, to say the least, to many Hong Kong residents. There were criticisms on various aspects of coordination in the rescue and the Government's support to the victims. The Coroner Court's report on the investigation of the deaths in the incident had led the Government to pledge to overhaul the emergency response system and to improve inter-department coordination in disaster response.

The Government has since then learned from other disasters, particularly from SARS in 2003 and the tsunami in Southeast Asia in 2004. Gradually, various procedures and contingency plans pertaining to disaster management have been devised and developed. Today, there are several emergency response contingency plans that the general public can access via the Hong Kong Special Administrative Region Government (HKSARG) website (Security Bureau, HKSARG 2010). In these contingency plans, the roles of various government departments are clearly delineated. Command lines and lines of responsibilities are spelled out and so are the ways these different departments are to be coordinating their services.

One of the contingency plans that is noteworthy is the Emergency Response Operations Outside the Hong Kong Special Administrative Region (HKSAR 2009) because this is the first plan in which the Government has officially recognized the importance of providing psychological services. The Social Welfare Department (SWD) is tasked to provide psychological support and care to the victims as well as emergency personnel affected:

> The SWD will where necessary:
>
> - provide counselling services for HKRs [Hong Kong Residents] in distress;
> - provide critical incident stress debriefing services for all members of a deployed external team; and
> - provide emergency financial and other assistance to those in genuine need. (HKSARG, 2009)

This brings us to the second major change in the period of development of psychological support services in response to disasters in Hong Kong. The Hong Kong Psychological Society (HKPS) formed a Critical Incident Team (CIT) in 1993 after the Lan Kwai Fong Incident. Members of the team worked enthusiastically to promote the need for psychological support for victims and emergency response personnel while at the same time explored useful interventions that are applicable to the local setting. They had provided assistance, in a voluntary capacity, in many of the local disasters noted earlier on. With the growing number and magnitude of the disasters, it soon became obvious that psychological support for disaster victims cannot be handled by volunteers alone. The turning point came in 1996, after the fire at the Garley Building when the Social Welfare Department (SWD) officially offered crisis management briefing to the victims. This was widely reported by the media and set the scene for the development of crisis intervention led by the government in response to disasters in the community. Within SWD, which is the largest employer of clinical psychologists (CPs) in the Government, Critical Incident Stress Management (CISM) in the International

Critical Incident Stress Foundation (ICISF) tradition, was endorsed and incorporated in the Department's internal procedure manual in disaster response. In 2001, the Departmental CISM team was formally set up in SWD and a manual of operation was developed to cover disasters of different nature and at different intervention points. The system was tested and developed through subsequent disasters of different nature and size. A parallel development took place in the Hospital Authority (HA), the largest non-Government employer of clinical psychologists where a civil disaster management plan was developed with due emphasis on provision of psychological support. Take the SARS attack in 2003 as an example, the support provided by both SWD and HA ranged from psychotherapy provided to traumatized patients and their families, grief counselling for survivors and family members of patients who unfortunately died, Critical Incident Stress Debriefing for hospital personnel, Crisis Management Briefing after massive quarantine and evacuation operations, disseminating psycho-educational materials to advise people in the community on how they should cope with the generalized anxieties, disruption of daily functioning brought on by home quarantine and by a territory-wide suspension of schools. When the acute crisis was over, the CPs of SWD were mobilized to conduct district seminars and briefings to help in the rebuilding of the community after the worst health epidemic in the history of Hong Kong. We have learned a lot from the SARS crisis. When the crisis was over, there were many seminars and working groups, whether Government- or NGO-led, to attempt to organize what was learned to further improve the system of response to disasters. Therefore, the SARS epidemic truly turned a new leaf in the history of disaster management in Hong Kong.

The third major change in this period was the evolvement of more clear-cut protocols for providing psychological services after disasters. When this line of work began in the late 1980s, no one in Hong Kong had any formal training in disaster psychology. The topic was simply not taught in the clinical psychology programme in the University of Hong Kong, the then only institute training clinical psychologists. The enthusiastic CPs who helped to develop post-disaster psychological services relied on their own intuition, clinical knowledge and experience. They provided crisis intervention and used group processes they learned from textbooks and their clinical practices. Through personal contacts and goodwill, they took up or referred cases for follow-up treatment by CPs in the government or NGOs. It was not until the late 1990s that the HA CPs invited the founders of the International Critical Incident Stress Foundation (ICISF), Dr George Everly and Dr Jeffrey Mitchell to conduct formal training on Critical Incident Stress Management (CISM) in Hong Kong. In 2001, SWD invited these two trainers to come back and conduct basic CISM for CPs and social workers in SWD. The training was also extended to CP trainees of the two local universities, the then Education Department, and CPs working in NGOs. Thereafter, many CPs of Hong Kong have a common language they speak when they are planning or delivering psychological support services. This is a very important development. The ICISF model is a multi-component model with different intervention strategies and protocol to meet with different needs at different points of time in a disaster or critical incident. It encompasses the basic principles of psychological first aid or early psychological intervention and its components are consistent with the recommended foci on mitigation, preparedness, response and recovery discussed earlier on. It utilizes a pragmatic, non-stigmatizing, supportive and need-driven approach. It allows the participation of non-mental health professionals in the interventions but emphasizes on the need that the interventions be led by mental health professionals such as clinical psychologists. In the ICISF model, there are different intervention strategies for different groups of service recipients covering pre-incident training, system development and public education to build up the resiliency of the community. Immediately after the disasters, interventions such as defusing, demobilization, and critical incident stress debriefing are used for small or large homogenous groups of emergency personnel. Crisis management briefing and individual crisis interventions are developed for large heterogeneous groups of civilians. At present, they form the basis of the many existing protocols used by the major service providers of psychological services in Hong Kong.

In SWD, crisis management briefing (CMB) is by far the most frequently used intervention. Examples are the CMB for members of the public after sensational and usually disturbing news of family violence has broken out in the community, such as the incidents in Tin Ping Estate in 1998 and Tin Shui Wai in 2004 and 2007, respectively. CMB was also applied during the 2003 SARS epidemic to residents of the Amoy Gardens when they were moved to a quarantine camp; to victims and residents of the Mei Foo Sun Chuen fire in 1999; and to members of the affected community after various incidents of suicide that aroused public attention and concern. Critical Incident Stress Debriefing (CISD) was provided to smaller, homogenous groups who were survivors of disasters or emergency response personnel returning from their duty. Examples were the CISD provided to tour guides who were stranded in Thailand and to Immigration Officers who returned from active duty after the tsunami in 2004; to firefighters who fought the blaze at the Garley Building in 1996; to survivors of a boat accident in Manila in 1997, in which tourists from Hong Kong were killed; and to social workers of SWD after several incidents of violence at the office where they were attacked by their clients. Because of the special nature and target population, other interventions like defusing and demobilizations have been less frequently used. The Hong Kong Police Force applied defusing and demobilizing to help front-line police officers to decompress after facing the confrontation against the demonstrators during the World Trade Organization's 6th Ministerial Conference in 2005.

Apart from CISM, there are of course other models that are being used in Hong Kong. For example, the American Red Cross in Hong Kong has its own protocol. However, the most commonly adopted model is CISM and this is directly a result of formal training in the model in recent years. I am sure that all of the trainers of CISM in Hong Kong are keenly aware of the limitations in this model and particularly the strong criticisms on one of the CISM components — Critical Incident Stress Debriefing (CISD). They are conscious of the need to adapt and modify the model for use in the local setting, and the need to collect local data to evaluate the model. However, initial feedback from the users seemed positive enough to warrant the continued use of this model as a foundation to build on for Hong Kong. It is the social and political reality nowadays that mental health professionals are expected to be involved. They are expected to advise on and to provide services to protect the mental health of the community after disasters. Inaction is not an option and the best way is to be conscious of the limitations of whichever model(s) that we are using and to seek to continuously improve our methods as we work.

The fourth and final major change in the field of disaster psychology in Hong Kong is the changed mentality of the public. In the past half-century, there has been significant economic development in Hong Kong. No one will argue that for the general public the standard of living and education have both risen significantly. When basic physical needs are met, people turn to satisfy their higher social needs. This explains the growing acceptance of and demand for psychological services in the past two decades or so. Apart from the natural development in people's needs, the pioneer work of psychologists, particularly that of clinical psychologists, in promoting mental health in Hong Kong must be given its due credit. Such promotion of course includes the education of the public on the psychological reactions to disasters and why or when they need to seek help. From the time that clinical psychologists were ridiculed by the news columnist when they offered help to reporters coming back from covering the 1989 Tiananmen Square story, to the time when the media demanded psychological support for Hong Kong victims of the tsunami in 2004, the public of Hong Kong has come a long way. The understanding of and acceptance by the general public of what professional psychologists do is very important, if not a prerequisite, to getting any community intervention programme off the ground. Bearing in mind that public needs also affect the policymakers and the administrators, the public's endorsement and demand for post-disaster psychological services will have very important implications for resources. On the other hand, given the resources, the interventions we provide will be meaningless if the public cannot accept them. It took years of education to get the people of Hong Kong to accept the work of the psychologists. Without this basis, post-disaster psychological services will not work.

The Hong Kong Scene — The Way Forward and Issues Yet to Be Addressed

To recapitulate, we have in Hong Kong now some established trends in providing psychological support services in response to disasters. When disaster strikes, the government will initiate a series of protocols to cope with different aspects of the disaster, according to existing contingency plans. The public will demand support services too. The key role of providing psychological support falls on the Social Welfare Department and the Hospital Authority, and help will be brought in from NGOs and other government departments when necessary. Depending on the needs identified in the public, various interventions ranging from crisis intervention to intensive psychotherapy or psychiatric treatment will be rendered. The International Critical Incident Stress Foundation (ICISF) model provides the basic framework for developing and implementing specific interventions at different points on the time-line of development of a disaster while the philosophy of psychological first aid (PFA) and early psychological intervention (EPI) is embodied by most who work in this field. At the recipient end, we have a public that is more knowledgeable of and receptive to the notion of psychological help after disasters. The basic ingredients are in place but we are still a long way from having a comprehensive disaster psychological support system. There are many important issues that we still need to work on.

To start with, there is the need for still more recognition from the Government and major service providers for the need to provide psychological support and the formal adoption of guidelines and policy to mandate the devising of such psychological support systems in the contingency plans of all organizations. Notwithstanding the public's continual criticisms of the Government, which seems a universal phenomenon, the Government will remain the single most important institution that can lead any sustainable effort to deal with the aftermath of large-scale disasters. The Government should in turn be informed by experts in the field in laying down the relevant policies and developing the necessary structures to respond to disasters. To make this possible, it is imperative for the psychologists who are in the position to do so to come to consensus regarding what and when interventions should be used. The consensus should be informed by the results of the on-going debate and discussion in this area worldwide plus local research results, if available. At any rate all must be wary of the need to translate or adapt the primarily Western ideologies when applying them in the local setting.

Ideally, there should be local research to back up the decisions made by practitioners in regard to the interventions that they should use and recommend to the Government. The least that practitioners can do is to have a continuous forum for exchange of views, updating of new research data and suggesting modifications and changes to what they are doing. It is also important to develop a comprehensive database of information pertaining to post-disaster psychological services. This should include types of interventions available, research data on such interventions, training programmes, records of trained personnel and their contact lists. In times of crisis, the handy database will be very useful.

While many psychological support programmes developed abroad encourage the use of volunteers, the use of laypersons in Hong Kong could be problematic. This is because of the different degree of sophistication in terms of education in general and education in psychology in particular. I strongly recommend that where laypersons are involved in post-disaster psychological support, they should work as aides to mental health professionals and should have relevant training beforehand. Even for mental health professionals, special training is required especially in crisis intervention or psychological first aid. They should also be knowledgeable of the intervention systems that they work in, the resources available and their distinct roles as crisis responders / disaster workers, roles that are invariably different from their normal roles as psychologists or psychotherapists. Training should be conducted by qualified trainers only. I have in recent years come across cases of training by unqualified psychologists. Consequently, I have seen misuse and misunderstanding of certain intervention strategies which do not do justice to the ones who developed such strategies and will perpetuate unnecessary disputes over the efficacies of such programmes, not to mention the ethical problems with the unqualified trainers themselves.

Psychological support services to disasters must match with other existing systems of disaster management. Teaching single interventions or set of interventions without developing associated support systems will often render such interventions ineffective. Trainers should be wary of the fact that they know more about the limitations of the intervention in which they are training. Therefore, it is their responsibility to promote the intervention that they teach very carefully, stating clearly the limitations of the interventions and how best they should be applied. If they were invited to provide training on a single intervention or set of interventions without given the opportunity to help the organizations concerned to develop the whole system to back such interventions, they should consider declining the invitation. Where they have helped to set up certain intervention systems, they should continue to provide consultation or advice with regard to the maintenance and improvement of such systems. They should also be prepared to render on-going consultation and advice to the administrators of the organization on the evaluation of the programme, on the necessary modification to suit specific organization needs or new demands from the community, and on the on-going training/retraining of suitable personnel. It is also of utmost important to constantly remind the administrators what specific types of interventions are appropriate for which types of needs identified from initial assessment after a disaster.

Lastly, there is no monopoly in the provision of psychological support services after a disaster. Although there are more established groups of providers, there is nothing to stop other small service providers to contribute after a disaster when every effort may help. However, there should be a forum for good communication among the service providers so that their efforts will not clash and the use of existing resources can be maximized. A properly developed crisis response network with everyone clear about what everyone else is doing is very important.

Conclusion

In this chapter I have reviewed the development of psychological support services in response to disasters both abroad and locally, introduced the current state of affairs in disaster psychology in Hong Kong, and discussed some important issues that will affect the future development of such services in Hong Kong.

There have been considerable advances in the past two decades in the local scene where post-disaster psychological support services are concerned but there are still many unanswered questions, and many aspects of the service to be improved on. It is only with concerted efforts and the sharing of common goals that such services can be further improved and benefit the service recipients more.

Let me end the discussion by quoting Reyes and Jacobs (2006):

> In the competition for disaster relief resources, psychosocial concerns are given more lip service than action. Basic survival needs are so clear and compelling that humanitarian mental health advocates find themselves relegated to the margins while central planning concerns are pursued with fervor. This is to some extent a necessary and reasonable situation, since mental health is a relative luxury in the face of mass destruction and death. Nevertheless, if psychosocial interventions are ever to be both timely and effective, they must move from being marginal concerns towards being integral and influential in the overall scheme of disaster response planning. At present the priorities are such that mental health and psychosocial support activities have more propaganda value than actual influence. This helps to keep the mental health sector in a reactive role, rather than supporting systematic, strategic development of responsive operational abilities and the undertaking of initiatives for building more resilient local capacity. Instead, the current state of affairs allows for a public voicing of compassion and vague claims of action for the anguish and trauma of the affected people, while the pace of response is more timid and tentative. This is to some extent due to legitimate doubts regarding the need for psychosocial interventions and an absence of evidence supporting the effectiveness of what is presently being offered. Thus,

> disaster mental health advocates will need to consider their steps carefully if they are to advance their cause while avoiding the temptation to overstate their importance at the risk of further undermining their precarious progress. (Reyes and Jacobs 2006, p. 184)

Although Reyes and Jacobs was writing about the international scene, his remarks and comments are certainly applicable locally. These should be borne in mind when we evaluate and further develop what we are doing for the people of Hong Kong.

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12

Applying Psychological First Aid from Disaster to Personal Crises:

Hong Kong Red Cross Community-based Psychological Support Programme

Wilson Wong

Introduction

The usefulness of providing a non-interventionist form of early psychological support to promote mental health after emergencies and crises has been documented in a number of settings (Litz, et al. 2002; McNally, Bryant, and Ehlers 2003; Ommeren, Saxena, and Saraceno 2005; World Health Organization [WHO] 2003). It is coherent with adopting a holistic approach to humanitarian assistance in providing not only medical, physical, and tangible support but psychological, social and intangible support to promote health in a broader dimension. Over the ongoing development in the past decade, the guiding principle for humanitarian assistance is no longer whether to provide psychological support but how to provide it in the most effective and appropriate way matching the immediate needs of people who are exposed to extreme stressors and meeting the authentic needs of the community.

Current early psychological support to promote mental health in emergencies or disasters is under the umbrella term of "psychological first aid". The nature of psychological first aid is generic and supportive using a non-interventionist approach to reduce initial distress in crises to foster short- and long-term adaptive functioning and coping. This entails basic, non-intrusive pragmatic care with a focus on listening but not forcing talk; assessing needs and ensuring that basic needs are met; encouraging but not forcing company from significant others; and protecting from further harm. This type of experiential and simple psychological support can be taught quickly to both volunteers and professionals. However, most of the psychological first aid programmes are based on disasters — both man-made and natural — or based on emergency relief, with little emphasis on supporting people who have experienced distress caused by other form of traumatic events or acute crises. Traumatic events such as the death of a loved one, divorce, and serious illness are examples of very challenging life experiences.

Many people react to such circumstances with a flood of strong emotions and a sense of helplessness. Acute crisis episodes from everyday life at home and at work frequently overwhelm our traditional coping skills, resulting in dysfunctional behaviour, feeling "being torn apart", intense fears, distress, and entering to a temporary state of psychological disequilibrium.

Traumatic events and acute crises experienced by millions of individuals and families in everyday life have been escalating in intensity and frequency within the Hong Kong context. Increasing incidences of family violence, the high divorce rate, diminished work productivity with accumulated work stress are precipitating by the effects of acute crises. High prevalence of these traumatic events and acute crisis episodes hamper the economic growth of a society with the impact caused by disasters. Applying the non-interventionist form of psychological first aid by trained volunteers from the community to help regain of equilibrium for people of the community who are exposed to extreme stressors caused by disaster, traumatic events or acute crisis episodes is an urgent need for Hong Kong. This community context sets a stage for extending the scope of psychological first aid in less disaster prone communities.

To extend the scope of usage, this chapter asserts applying psychological first aid to people who have experienced traumatic events in a broader sense not only in disaster relief service also in community crisis setting. By introducing the experience of Hong Kong Red Cross Community-based Psychological Support Programme with the volunteer-based non-interventionist form of psychological support for crisis stabilization, provides reference for other Red Cross National Societies to adopt psychological first aid in accordance to the uniqueness of their own community.

Psychological First Aid in Disaster

Each day disasters occur, and each year millions of people are affected. The extreme and over-whelming damage caused by disaster can have devastating effects on individual, community, and national stability. Events associated with disaster causing traumatic stress for survivors who experienced threaten death, serious injury, loss of a love one, and significant loss of property. Disastrous events may last from seconds to a few days, effects on communities and individuals can continue from months to years during the extended process of recovery, reconstruction and restoration. Obviously, a timely and effective health care and tangible physical support is crucial to the survivors' and to maintain the community's safety and recovery. Emergency mental health care is also an essential component in response to disaster.

Psychological first aid is a first order intervention to be provided in the acute phase and reconsolidation phase in emergencies to promote mental health (WHO 2003). Psychological first aid is a basic, non-intrusive pragmatic care with a focus on listening but not forcing talk; assessing needs and ensuring that basic needs are met; encouraging but not forcing company from significant others; and protecting from further harm. It is a form of early intervention for recently traumatized people through providing comfort, information, support and meeting people's immediate practical and emotional needs (Litz et al. 2002). Psychological first aid is an evidence-informed modular approach to help children, adolescents, adults, and families in the immediate aftermath of disaster. It is designed to reduce the initial psychological impact caused by traumatic events and to foster short- and long-term adaptive functioning and coping. It may be used in close proximity to where the event took place. It can be an immediate intervention by a non-professional, and it is experiential and simple. It can also be provided to first responders and other disaster relief workers.

Psychological first aid is primarily toward "normal" people responding normally to an abnormal situation, and to identifying persons who are at risk for severe psychological or social impairment. Psychological first aid does not assume that all disaster survivors will develop severe mental health problems or long-term difficulties in recovery. Instead, it is based on an understanding that they will experience a broad range of early reactions in physical, psychological, behavioral and spiritual dimensions. Some of these reactions will cause enough distress to interfere with adaptive coping, and recovery may be helped by support from compassionate and caring human interactions.

Psychological First Aid in Humanitarian Assistance by Red Cross

The need for psychological support is driven by research findings, that people closest to extreme stressors, are more at risk for physical and psychological disorders, harmed mental functioning, and antisocial behaviour. The International Federation of Red Cross and Red Crescent Societies (IFRC), an international humanitarian organization with 185 members of National Societies world-wide, has been a pioneer in the development of psychological support programmes. A Federation Reference Centre for Psychological Support was established in 1993 and has since been a partner in the development of psychological support activities and in assisting National Societies in providing an essential service of psychological support to people in need. The International Federation addresses three target groups who suffer from a variety of psychological reactions and need support: a) the victims and other people affected by the event, b) volunteers and staff engaged in disaster response and c) expatriate delegates. Psychological support is seen as a crosscutting issue relevant both in disaster preparedness, disaster response, first aid, emergency health and development programmes like community health, HIV/AIDS and social welfare projects.

The Danish Red Cross has been a leader in providing guidance in teaching and applying psychological first aid and human support since 1997. One year later, the IFRC Reference Center for Psychological Support has started developing materials, conducting PFA training in over 100 National societies, and documenting psychological first aid activities during natural and man-made disasters. The IFRC developed and published a psychosocial support policy in 2003. On top of applying psychological first aid for disaster relief, the same idea is also applied to promoting individual and community resilience.

Community-based Psychological First Aid in Hong Kong Context

Increasing negative impact of family violence and frequency of traumatic events in the Hong Kong context demand an urgent need of timely psychological support provided by lay people who are close to the person in crisis. When a sufficient number of lay people have been trained with some practical and easily implemented psychological supporting skills, they can immerse in the community, playing an active role of psychological first aider, providing timely support to bolster the available coping method for people in crisis and in disaster. The Hong Kong Red Cross (HKRC), with its strong volunteer force, began to set up psychological support services in 2003 with the vision to gather volunteer resources offering on-site service to affected people during times of emergencies, critical incidents and in crisis.

Crisis intervention is emergency first aid for mental health (Ehly 1986). Crises can be triggered by exposure to extreme stressors in critical events, such as disasters, conflicts, wars, accidents, epidemics and also by stressful life events like life-threatening illnesses, family problems, relationship problems, financial problems, and work problems which bring social and psychological disequilibrium that undermine people’s ability to carry on with their lives. The Chinese language contains two characters, which taken together connote the concept of crisis. The first character, “危” (“wei”), indicates a critical or dangerous situation, while the second one, “機” (“ji”), means an opportunity for change, together forming a vocabulary word meaning “crisis”, which is a critical point in time that allows the opportunity to change. The Chinese language has insightful meaning to the nature of crisis.

A stressful event alone does not constitute a crisis; rather, crisis is determined by the individual’s view of the event and response to it. How a person perceives the crisis, especially how the event fits in with the person's existing frame of reference about life, determines whether the situation is critical. People react differently to the same traumatic event: some may cope in a positive way and experience a manageable amount of stress, while other people may experience a crisis state because of inadequate coping skills and overly pessimistic interpretation of the situation (Roberts 2005). Crisis is a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms (James and Gilliland 2005). Existing means of coping and managing problems break down in the face of current threats and challenges. The potential for good or bad outcomes lies in the disorganization and disequilibrium of crisis. Some form of personal reorganization will begin in a matter of weeks after the onset of crisis. The reorganization may be toward growth and positive development or toward psychological impairment. A crisis is a temporary state of upset and disorganization, characterized chiefly by an individual's inability to cope with a particular situation using customary methods of problem solving and by the potential for a radically positive or negative outcome. A crisis state is time limited, is usually touched off by some precipitating event, can be expected to follow sequential stages, and has the potential for resolution toward higher or lower levels of functioning.

Although people do not react the same to traumatic and stressful life events, exposure to extreme stressors is a risk factor for mental and social problem. Addressing the psychological as well as the physical needs by restoring their capacity to cope is a prominent concern in humanitarian assistance to protect life and health. Forming a community-based psychological first aid team with a significant number of trained volunteers to help people in crises to regain equilibrium is the mission of the Hong Kong Red Cross Community-based Psychological Support Programme.

Hong Kong Red Cross Psychological Support Programme — Community-based psychological first aid

Unlike other disaster-prone regions, as noted earlier, the extreme stressors that affect Hong Kong community are less likely to be disaster-based but more likely to be crises caused by heavy life pressures and family problems. Provision of psychological support is adjusted accordingly under the concept of psychological first aid to better match with the community's needs. The aims of the programme are three-fold: (1) enhance the community's resilience in facing adversities through public education; (2) alleviate psychological suffering and disturbances for people affected by disaster, critical incidents and extreme stressors by providing psychological first aid and crisis intervention; (3) assist responders to manage stress for quality service in the field work.

Principles and techniques of community-based psychological first aid have to meet four basic standards. They have to be: (1) consistent with research evidence on risk and resilience following trauma; (2) applicable and practical in community settings; (3) appropriate for developmental levels across the lifespan; and (4) delivered in a flexible manner. The ultimate goals are: to bolster available coping methods or help individuals reestablish coping and problem-solving abilities while helping them to take concrete steps toward managing their feelings and developing an action plan; to reduce lethality and potentially harmful situations and provide referrals to community agencies when needed; and to reinforce strengths and protective factors for people to regain equilibrium.

The programme adopts a multi-level team structure composed of mental health professionals and trained volunteers to provide psychological first aid in the community. See Figure 12.1 for the Hong Kong Red Cross Community-based Psychological Support Programme structure.

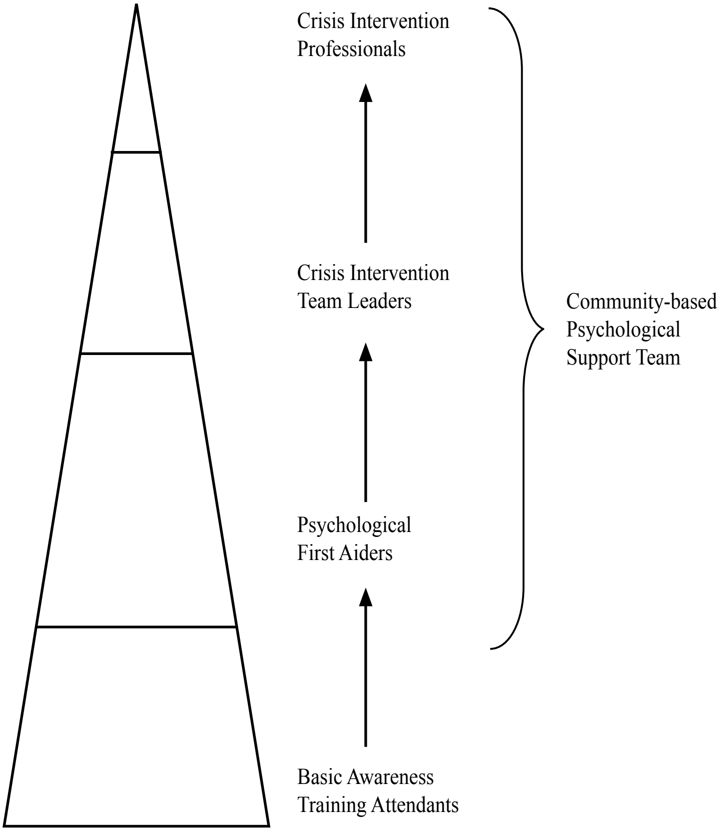

Figure 12.1 Hong Kong Red Cross Community-based Psychological Support Programme Structure

The programme includes elements of training, practice, continual development and a line of supervision. It aims to mobilize a volunteer force to provide psychological first aid in Hong Kong and to increase public awareness on the principles of resilience when facing adversity. The programme members are from various backgrounds, including clinical psychologists, registered nurses, disaster relief officers, social workers, counselors, and volunteers. The volunteer force consists of professionals and non-professionals, the former being medical doctors, nurses, social workers, counselors, teachers, and police officers; and the latter including students, working adults from business and technical fields, housewives, and retirees. The volunteer force is in a four-level team structure: level one — basic awareness attendant, level two — psychological first aider, level three — critical intervention team leader, and level four — crisis intervention professional.

Level one training is a form of community resilience education. The objective of the basic level training is to increase the attendants' awareness of resilience as the process of adapting well in the face of adversity, trauma, tragedy, threats, or even significant sources of stress. Understanding that resilience is a capacity that each of us has in different extents helps us "bounce back" from difficult experiences and adversities. Resilience generally refers to a class of phenomena characterized by patterns of positive adaptation in the context of significant adversity or risk (Masten and Reed 2005). Resilience does not come from rare and special qualities but from the operations of ordinary human systems, arising from the brain, mind, and body since childhood, from relationships in the family and community, and from schools, religions, and other cultural traditions. The public education medium can convey to the community the importance of being resilient in face of adversity, to improve their ways of coping from interpretation of the stressors to self-help and seeking supportive resources.

Level two psychological first aiders are volunteers who have completed four 3-hour training sessions on the principles and application of community-based psychological first aid. The programme takes the first step in Hong Kong to prepare trained volunteer psychological first aiders to provide timely support for people in crisis. This level of training contains two modules: psychological first aid for disaster and psychological first aid for personal crisis. The disaster relief module is a five-step process that consists of satisfying basic needs, listening, validating and understanding the person in need, defusing the situation and planning next steps, and referral to community based networks. The module also includes training in basic psychological support skills in listening, empathy, genuineness, positive regard and guiding. The crisis intervention module is a seven-step process originated from Roberts's seven-stage crisis intervention model: (1) Plan and conduct a crisis assessment; (2) Establish rapport and rapidly establish relationship; (3) Identify major problems; (4) Deal with feelings and emotions; (5) Generate and explore alternatives; (6) Develop and formulate an action plan;

(7) Establish follow-up plan and agreement (Roberts 2005). The module focuses on providing comfort, information, support, meeting people's immediate practical and emotional needs, also allowing for cognitive re-orientation to enhance people's immediate coping with a highly stressful event. Since 2003, approximately 140 volunteers have received community-based psychological first aid training in Hong Kong.

Level three crisis intervention team leaders are selected psychological first aiders who have completed six 3-hour training sessions on advanced psychological support skills and leadership skills. Their role is to lead a group of psychological first aiders in delivering services and serve as immediate supervisors of the group when further consultation/referral arrangement is required. They have acquired skills to identify persons who are at risk for severe psychological or social impairment and make referrals accordingly. Stringent education and personal orientation criteria are followed for the selection of psychological first aiders to join the crisis intervention leader team. They are required to have university education, preferably having mental health professional training or related background, and possess personal orientation of adventuresomeness, maturity, sociability, and calmness. The third level training covers issues of providing timely and suitable support in the context of when, where, and with whom. "When" is classified by three temporal phases: emergency phase, early post-impact phase, and restoration phase. "Where" is classified by site: on-site and off-site. "Whom" is classified by an individual's age and role of function including child, adult, older adult, and responders.

Level four of the programme structure is a group of crisis intervention professionals, composed of clinical psychologists from the Hong Kong Red Cross and an advisory panel with external advisors who are representatives of the professional bodies in the field. The external advisors are volunteer mental health professionals who carry the role of supervising crisis intervention team leaders and also serve as the bridge between the programme and other community mental health services. This top level provides guidance and support for the programme in the development of service direction, updated knowledge, and best practices for those who are in need of such service. The crisis intervention professionals also review background materials, existing guidelines, decisions and practices regarding psychological support service deliberations and processes, as well as provide direction for strategic planning, development and management. The panel plays a role in monitoring and evaluating the program management and response performance, and providing suggestions for process improvement and quality assurance. It also takes part in identifying areas of cooperation with other jurisdictions with the aim of establishing a more comprehensive disaster response and support service.

Conclusion

Everyone has the right to learn how to apply basic psychological support appropriately in their daily context both to increase their resilience in facing advertises and to provide supportive and non-interventionist psychological first aid to people in need. The Hong Kong Red Cross Community-based Psychological Support Programme accepts volunteers from all walks of life to equip themselves with the principle of psychological first aid and to serve the community by offering the skills learned. Relevant training programs, continuous education and service opportunities, and a system of supervision are major components to ensure the service quality. The programme is as an example of applying psychological first aid in a broader context other than disaster relief, which is community need. It provides reference for other Red Cross National Societies to adopt psychological first aid in accordance to the uniqueness of their own community.

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13

Report on the Model of Psychological Service Adopted for the Deyang Rehabilitation, Prosthetic and Orthotic Centre for Survivors of 5.12 Earthquake in Sichuan, China

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Introduction

A magnitude-8 earthquake struck 92 kilometres north-west of Sichuan's provincial capital, Chengdu, on 12 May 2008. According to World Health Organization (WHO 2008), a total of 18,084 aftershocks had been detected after the quake, reported casualties as of 16 July included 69,197 people dead, 374,176 people injured, and 18,238 people missing. The number of people affected was 46.24 million. Among the earthquake sites, Deyang was one of the most affected areas. The death toll has reached 17,137 there; 74,086 people were injured and 570 people were reported missing. Among the injured, thousands of them have become disabled and required amputation (Hong Kong Red Cross 2008).

Besides ensuring water and food safety, and attention to environmental issues, WHO includes immediate and long-term mental health and psychosocial support, as well as long-term rehabilitation of injured and disabled patients in the list of top eight health problems for the disaster (WHO 2008). According to WHO's recommendations for mental health and psychosocial support after disasters, based on epidemiological projections of the magnitude of mental health problems and psychosocial distress after a disaster, about 20% of survivors may have mild to moderate mental disorders (e.g., depression, anxiety, and posttraumatic stress disorder [PTSD]) 12 months after the disaster. WHO has also indicated that there was a low level of help-seeking behaviour for PTSD symptoms in many non-Western cultures, thus psychological distress other than PTSD has to be considered when providing mental health service for disaster survivors (WHO 2005).

The Deyang Rehabilitation, Prosthetic and Orthotic Centre (the Centre), is jointly operated by the Hong Kong Red Cross (HKRC) and the Deyang Disabled Persons' Federation. The Centre is the first rehabilitation, prosthetic and orthotic institute which provides prosthesis installment and comprehensive rehabilitation to the affected communities of the 5.12 Earthquake free of charge. The Centre was officially opened 6 months after the earthquake in November 2008; ground work and initial operations have started since July 2008 (HKRC 2008). It is hoped that the service for the local community will benefit from the co-operation between local and Hong Kong professionals as the advanced technologies, clinical and management experiences of the Hong Kong professionals will be utilized and integrated with the system and practice of the local culture (HKRC 2008).

The present report aims to document the service model adopted for the psychological service of the Centre, a pioneer in bringing Hong Kong and local psychological professionals together in providing service for earthquake survivors. The occurrence and risk factors associated with PTSD, anxiety and depression identified via self-report measures for patients of the Centre was examined.

Rationale in the build-up of the components of the service model

Based on the database and guidelines of an international standard, including the WHO Framework for Mental Health and Psychosocial Support After the Tsunami in Southeast Asia (WHO 2005), the PTSD Guideline from the National Institute for Health and Clinical Excellence (NICE 2005) and the experience of psychological recovery work after the 9.21 Earthquake in 1999 in Taiwan (台灣心理學會 2002), the psychological service provided in the Centre adopts a comprehensive and integrated approach.

The basic rationale of the service model is to integrate existing international consensus and evidence-based approach with considerations of culturally relevant needs for provision of psychological service after the earthquake. In particular, for the high-risk group of disaster survivors including patients and their family caregivers of the Centre and the identifiable community with specific ongoing distress like physical disability, “screen and treat” was adopted as the basic rationale for provision of screening and early intervention services. Screening tools used have been validated with the Chinese population in Hong Kong and were adapted with input from local counselors (心理咨詢師). The screening and early intervention programme were designed not only for PTSD features, but included other mental health issues such as anxiety, depression, complicated grief, and other cultural relevant psychosocial issues (e.g., perceived emotional support and socioeconomic needs). Another rationale adopted in the service model was the utilization of both manual-based and individual tailor-made intervention programme. While tailor-made treatment programme is usually considered as the preferred choice of intervention in clinical practice because individual client’s needs are unique, the provision of culturally adapted evidence-based intervention manual would facilitate service providers who may not be experienced in working with disaster survivors to provide early and effective intervention. Manual-based intervention would also assist empirical evaluation of service outcome. Considerations had also been given to empowering local professionals by working together with them in building up the service model, actual delivery of service, and provision of continuous training.

Based on these considerations, the scope of psychological service in the Centre encompasses different populations affected by the disasters, which includes: (1) centre-based service for patients (children and adults) and their family caregivers, (2) outreach/district-based service for patients discharged from the Centre and their family caregivers, (3) outreach/district-based service for identifiable community of disaster survivors (e.g., schools, hospitals and temporary home resettlement area), and (4) training of local professionals. Personnel of the psychological service include: (1) experienced clinical psychologists in Hong Kong as honorary consultants to assist in planning, development, supervision, and training for the service, (2) clinical psychologists with qualified master's degrees in clinical psychology in Hong Kong as stationed clinical psychologists to provide various levels of psychological service, (3) local counselors to provide screening and counselling service, to liaise with local agencies, and to assist development of a culturally relevant service.

The model of psychological service planned for the centre is schematically presented in Table 13.1. The service coverage and outcome documented in August 2009, one year after the commencement of service, are summarized below.

Service Coverage

Service for primary and secondary service receivers — patients and their family caregivers

By August 2009, one year after the commencement of psychological service in the Centre, 657 (87.6%) in-centre and outreach patients of the Centre has received at least one of the services provided by the psychological service. Among them, 128 (19.5%) required further clinical psychological service for diagnostic assessment or intervention. There were also 78 family caregivers who have received screening service and among them 12 (15.4%) were found to have persistent distress requiring further clinical psychological service.

Educational programme

Based on existing literature (Brymer et al. 2006; Smith, Dyregrov, and Yule 2002; 台灣心理學會 2002), a four-session psychological recovery group programme was developed to enhance psychological recovery of children and adolescents

Table 13.1 Model of psychological service for the Deyang Rehabilitation, Prosthetic and Orthotic Centre

Targets	Educational Service	Screening Service	Intervention for those found to have persisting distress in screening		Tracking needs & outcome	Training
			Manual-based	Tailor-made		
Primary Service Receivers: Child						
Patients of the Centre or identified survivors in the community	4-session manual-based psychological recovery group programme[a]	Screening by standardized structured survey and validated self-report measures: CDI & CHIES-R	• 5-session manual-based individual brief CBT for PTSD[c] • 6-session manual-based individual brief CBT for traumatic grief[d]	Individual-based psychological intervention	Follow-up by telephone, interview, or visit at 3-month & 6 month utilizing self-report measures	Not applicable
Primary Service Receivers: Adult						
Patients of the Centre or identified survivors in the community	2-session manual-based psycho-education group programme[b]	Screening by standardized structured survey and validated self-report measures: HADS & IES-R	4-session manual-based individual brief CBT for PTSD[e]	As above	As above	Not applicable
Secondary Service Receivers						
Parents of child patients of the Centre or identified child survivors in the community	1-session manual-based psycho-education group programme for parents whose child will receive psychological recovery group programme[a]	As above	1-session manual-based psycho-education programme for parents whose child will receive brief CBT for PTSD or traumatic grief[c, d]	As above	As above	Not applicable
Caregivers or family of adult patients of the Centre	2-session manual-based psycho-education group programme[b]	As above	4-session manual-based individual brief CBT for PTSD[e]	As above	As above	Not applicable

Tertiary Service Receivers						
Local Red Cross relief workers	1-session group education programme on psychological reactions & self-care	As above	4-session manual-based individual brief CBT for PTSD[e]	As above	As above	Not applicable
Local mental health professionals & volunteers	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	• Psychological First Aid • Continuous education programme on various mental health topics

Notes: [a] 胡潔瑩、陳潔冰, 2008a; [b] 胡潔瑩、陳潔冰、洪凱揚、葉以霆 2008; [c] 胡潔瑩、陳潔冰 2008b; [d] 陳潔冰、胡潔瑩 2008; [e] Wu, Li, and Cho 2008

(胡潔瑩、陳潔冰 2008a). For adults, a two-session psycho-educational group programme was used (胡潔瑩、陳潔冰、洪凱揚、葉以霆 2008). These group programmes aim at acknowledging normal stress response after the earthquake, enhancing the confidence of participants in re-establishing normal life routine and the knowledge in self-care, stress coping and mastery of relaxation techniques.

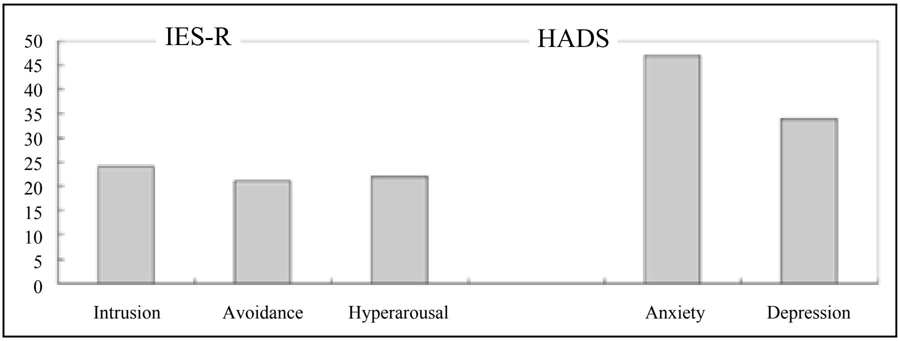
For the children's programme, child-friendly activities were utilized for teaching of relaxation techniques (胡潔瑩、陳潔冰、沈孝欣 2001). Group discussion and child-friendly exercises were used to heighten their awareness on the safety measures adopted in school after the earthquake. The programme also included one psycho-educational session for parents. The aims of the parent's session were to empower parents with knowledge of common psychological reactions and caring for the psychological needs of their children after the earthquake, and the aims and process of the educational programme for their children. A training session on utilization of the four-session psychological recovery group programme for children has been conducted for local professionals including teachers, doctors and counselors immediately after the commencement of psychological service in the Centre.

Screening service

As suggested by NICE (2005), for individuals at high risk of developing PTSD or other psychological distress following a major disaster, consideration should be given to the routine use of a brief screening instrument one month after the disaster. For the present service, standardized tools validated for Chinese population were used for screening of PTSD and psychological distress. For children, the Children's Impact of Event Scale-Revised (CHIES-R; Wu, Chan, Hung, and Cho 2008) and Chinese version of Children's Depression Inventory (CDI; Taskforce for Research on Child Neuropsychological Profile in Hong Kong, 2008; Kovacs 1992) were utilized. For adults, Chinese versions of the Impact of Event Scale — Revised (IES-R; Wu and Chan, 2003, 2004) and Hospital Anxiety and Depression Scale (HADS; Leung, Ho, Kan, Hung, and Chen 1993) were used. These scales have been used in previous research for psychological screening after traumatic experience for Chinese children (Wu et al. 2008) or adults (Wu and Chan 2004; Wu, Chan, and Ma 2005a, 2005b). Besides screening, these scales were used for monitoring outcome and tracking of needs for patients and caregivers at 3 months and 6 months after they attended their first multidisciplinary joint clinic of the Centre, which is an intake procedure of the Centre for new patients.

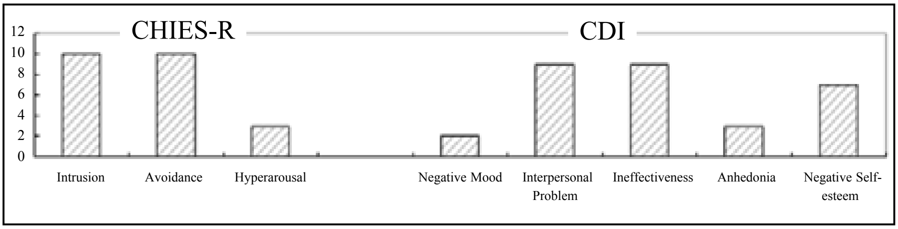
A standardized intake/screening protocol administered by staff in a question-and-answer format has also been developed and used to facilitate the collection of demographic information, screening for potential risk factors and persistent distress. This protocol would be the main tool of screening for patients who were not able to fill in the standardized self-report measure because of limited literacy.

Among the 87 child patients of the Centre who have received screening service, 66 (75.9%) were able to fill in CDI and CHIES-R. For adults, 169 (38.3%) of 441 patients, and 10 (12.8%) of 78 caregivers who have received screening service were able to fill in HADS and IES-R. Based on previous literature on screening of persistent distress after trauma for Chinese population, the mean subscale score of 2 for IES-R and CHIES-R (i.e., moderate level of distress), subscale score of 8 for HADS and subscale T-score of 65 for CDI were adopted for identification of persisting psychological distress for patients and their family caregivers (Wu and Chan 2004; Wu, Chan, and Ma 2005a, 2005b; Wu et al. 2008). Based on these measures, the percentages of patients and their family caregivers having significant level of distress related to posttraumatic stress, anxiety and depression (Figures 13.1 to 13.3) and associated risk factors were identified (Wu, Ip, Hung, Chan, and Leung 2009).



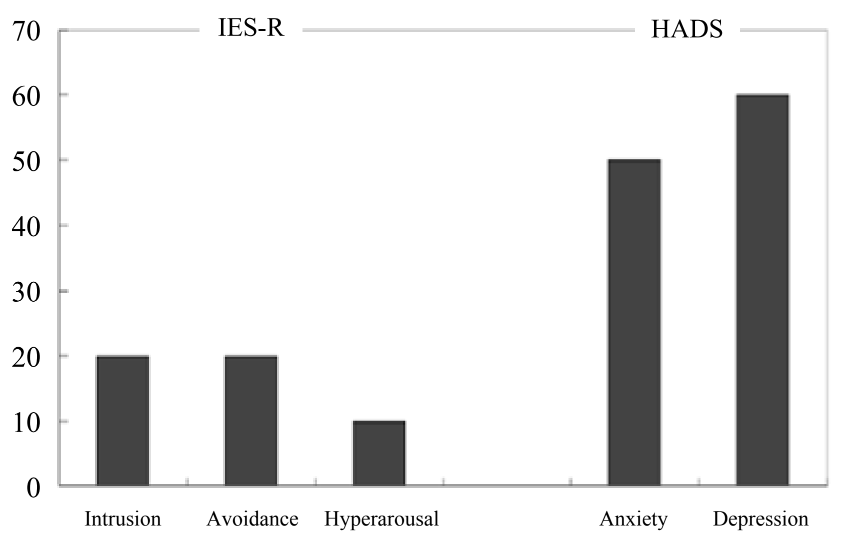
Note: Significant distress is defined by the mean subscale score of 2 for IES-R (i.e., moderate level of distress) or subscale score of 8 for HADS.

Figure 13.1 Percentage of Adult Patients with Significant Distress Based on IES-R and HADS



Note: Significant distress is defined by the mean subscale score of 2 for CHIES-R or subscale T-score of 65 for CDI

Figure 13.2 Percentage of Child Patients with Significant Distress Based on CHIES-R and CDI



Note: Significant distress is defined by the mean subscale score of 2 for IES-R (i.e., moderate level of distress) or subscale score of 8 for HADS.

Figure 13.3 Percentage of Family Caregivers with Significant Distress based on IES-R & HADS

To investigate the risk factors predicting psychological distress for patients, multivariate analysis of variance (MANOVA) on IES-R and HADS subscale scores was conducted. The effect of discrete predictors examined included: (1) gender, (2) amputation, (3) injury of significant others in the earthquake, (4) loss of significant others in the earthquake, and (5) history of past trauma. Pearson correlations followed by stepwise multiple regressions were used to examine the relationship between IES-R and HADS subscales with the following continuous variables: (1) age, (2) education level, defined by a 7-level scale ranging from 0 (below primary), 1 (primary), 2 (junior high), 3 (high), 4 (technical secondary), 5 (junior college), and 6 (university or above) (3) perceived life threat, defined by a 5-point rating scale ranging from 1 (not at all) to 5 (extremely serious) and (4) perceived emotional support, defined by the number of people one could talk to and share worries with in a 4-point rating scale ranging from 1 (no one) to 4 (four or above). Detailed data on the characteristics of subjects on these predictors in the sample used for analysis can be obtained from the first author.

There were 119 adult patients who were able to provide data for analysis of categorical predictors. Results of MANOVA showed significant interaction effect of gender and history of past trauma (*Wilks* = .86, $F(5, 91) = 3.00$, $p < .05$, *partial eta squared* = .14). Examination of univariate F tests indicated a significant two-way interaction effect of gender and history of past trauma ($F(1, 95) = 4.15$, $p < .05$, *partial eta squared* = .04) for the IES-R Hyperarousal subscale (Figure 13.4).

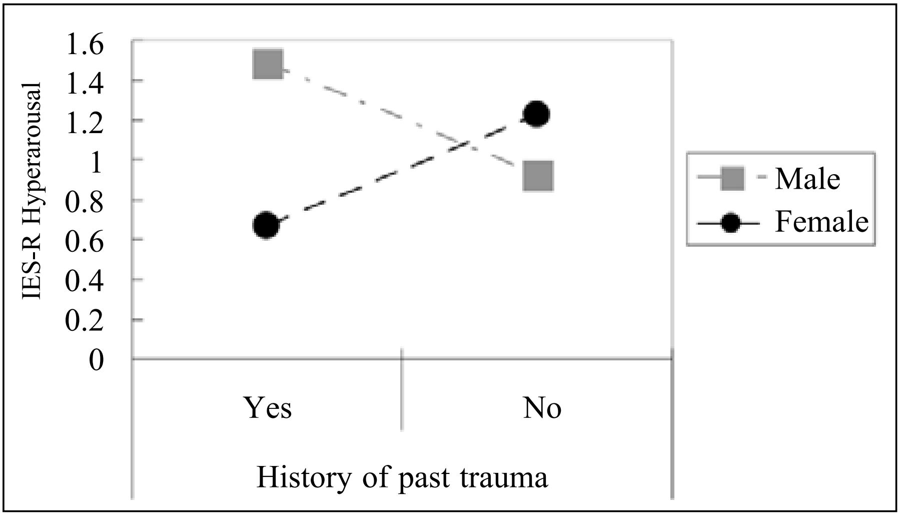


Figure 13.4 Interaction Effect of Gender and History of Past Trauma on IES-R Hyperarousal Subscale Score for Adult Patients

There were 81 adult patients who were able to provide data for examination of predictors that were continuous variables. Pearson correlations showed that age, education level, perceived life threat and perceived emotional support were significantly correlated with various IES-R and HADS subscale scores. Stepwise multiple regressions were conducted for comparing the effect of these predictors on IES-R and HADS scores. Results showed that higher perceived life threat was significantly related to higher symptom severity in post-traumatic stress (i.e., intrusion, avoidance, hyperarousal), anxiety and depression; lower perceived emotional support was associated with higher symptom severity in hyperarousal, anxiety and depression; and older patients were found to have higher symptom severity in intrusion, hyperarousal and depression (Table 13.2).

For child patients, 54 of them were able to provide data for analysis of categorical predictors. The main effect of amputation (*Wilks* = .70, $F(9, 42) = 2.03$, $p = .06$, *partial eta squared* = .30) were marginally non-significant. Results of univariate F tests showed that CDI Negative Self-Esteem subscale score for amputated children (M = 52.56; SD = 9.51) was significantly higher than that for non-amputated children (M = 46.55; SD = 7.91), $F(1, 50) = 6.34$, $p < .05$, *partial eta squared* = .11 (Figure 13.5).

Table 13.2 Summary of multiple regression analyses for predictors of IES-R & HADS scores for adult patients (n = 81)

Dependent variable Predictor variable	B	SE(B)	beta	sr^2	r	R^2	Overall F
IES-R Intrusion						.21	*F*(2, 78)=10.21 ***
Perceived life threat	.25	.07	.36	.13	.36**		
Age	.02	.01	.29	.08	.29*		
IES-R Avoidance						.06	*F*(1, 79)=5.40 *
Perceived life threat	.17	.07	.25	.06	.25		
IES-R Hyperarousal						.22	*F*(3, 77)=7.21 ***
Age	.02	.01	.29	.08	.28**		
Perceived life threat	.18	.07	.24	.06	.24*		
Support	-.20	.10	-.22	.04	-.21		
HADS-Anxiety						.15	*F*(2, 78)=7.01 **
Perceived life threat	1.13	.40	.30	.09	.29**		
Support	-1.08	.52	-.22	.05	-.22*		
HADS-Depression						.30	*F*(3, 77)=11.15 ***
Perceived life threat	1.37	.35	.38	.14	.38***		
Support	-1.16	.46	-.25	.06	-.24**		
Age	.07	.03	.24	.05	.23**		

Notes: Perceived life threat = rating on perceived life threat; Support = reported number of people with whom the participant could talk to and share worries; Age = age of the participant; Education = education level of the participant.

* *p*<.05; ** *p*<.01; *** *p*<.001

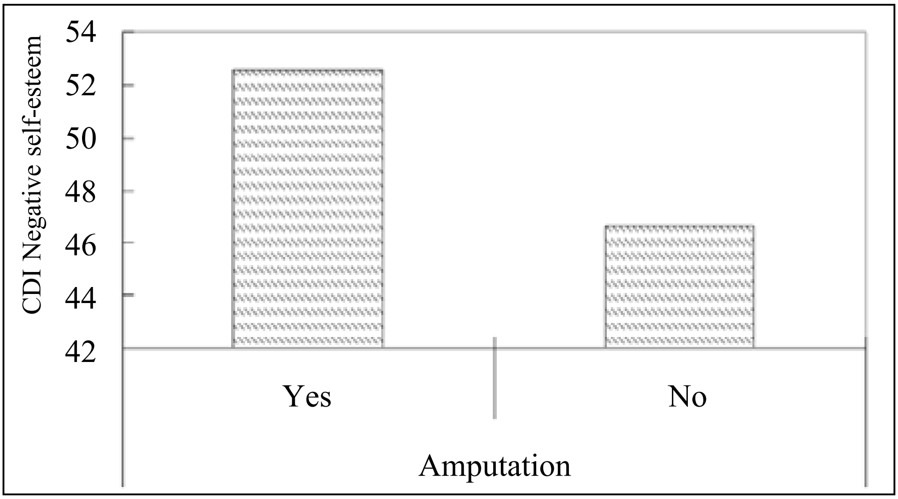


Figure 13.5 Effect of Amputation on CDI Negative Self-Esteem Subscale T-Score for Child Patients

There were 38 child patients who were able to provide data for examination of predictors that were continuous variables. Pearson correlations showed that age, education level and perceived life threat were significantly correlated with various IES-R scores. Result of stepwise multiple regressions revealed that higher perceived life threat was significantly related to higher symptom severity in intrusion and hyperarousal; older children were found to have higher symptom severity in avoidance; and higher education level was related to higher symptom severity in hyperarousal (Table 13.3).

Table 13.3 Summary of multiple regression analyses for predictors of CHIES-R scores for child patients (n = 38)

Dependent variable Predictor variable	B	SE(B)	beta	sr^2	r	R^2	Overall F
IES-R Intrusion						.25	*F*(1, 36)=11.84 **
Perceived life threat	.35	.10	.50	.25	.50**		
IES-R Avoidance						.13	*F*(1, 36)=5.21 *
Age	.16	.07	.36	.13	.36*		
IES-R Hyperarousal						.31	*F*(2, 35)=7.71 **
Perceived life threat	.23	.09	.37	.14	.37*		
Education	.54	.22	.35	.12	.35*		

Notes: Perceived life threat = rating on perceived life threat; Support = reported number of people with whom the participant could talk and share worries; Age = age of the participant; Education = education level of the participant.

* $p<.05$; ** $p<.01$; *** $p<.001$

Psychological treatment

Individual tailor-made psychological intervention was offered to patients and caregivers found to have persisting psychological difficulties in the screening process. In addition, manual-based psychological treatment programmes were also developed for specific difficulties to assist clinicians in providing timely, structured and evidence-informed treatment.

For children identified to have mild to moderate distress related to PTSD or traumatic grief, treatment manuals on brief cognitive behavioural therapy (CBT) was available. Based on previous literature on use of CBT for the treatment of PTSD (Bisson 2003; Bisson, Shepherd, Joy, Probert, and Newcombe 2004; Brymer et al. 2006; Resick, Jordan, Girelli, and Hutter 1988; Resick, Monson, and Chard 2007) and, in particular, for children (Smith et al. 2002), a five-session individual-based brief CBT treatment programme for PTSD was developed (胡潔瑩、陳潔冰 2008b). Treatment focused on providing psycho-education on stress response after disaster; identification of factors leading to persisting post-traumatic stress; exposure for habituation; and enhancement of coping with realistic self-statements, problem solving, and mastery of relaxation techniques. Referencing previous literature on use of CBT for the treatment of traumatic grief for children (Cohen, Mannarino, and Deblinger 2006; Melhem et al. 2004), a six-session individual-based brief CBT treatment programme for traumatic grief was developed (陳潔冰、胡潔瑩 2008). Treatment focused on providing psycho-education on grief reactions after losing significant others in the earthquake to enhance adaptive acceptance and expression; identification of factors leading to persisting traumatic grief; exposure for habituation; and enhancement of coping with realistic self-statements, problem solving, and mastery of relaxation techniques. Child-friendly activities were included for achieving the above aims in the programmes. Both treatment programmes include a one-session psycho-educational programme for parents. The aims of this session are to empower parents with knowledge of post-traumatic stress or traumatic grief reactions in children after the earthquake, the aims and process of the treatment programme attended by their children.

For adults found to have mild to moderate level of PTSD features, a four-session individual-based brief CBT treatment programme could be utilized (Bisson et al. 2004; Wu, Li, and Cho 2008). Treatment focused on providing psycho-education on stress response after disaster, exposure for habituation, and cognitive work on confronting negative assumption and use of realistic appraisal.

When this report was written, among the patients and their family caregivers who have received screening, there were 21 (24.1%) child patients, 98 (22.2%) adult patients and 12 (15.4%) family caregivers who required individual tailor-made psychological intervention. The manual-based intervention has been utilized only for a small portion of child and adult patients, but these manuals have formed as a reference in the tailor-made treatment programme.

Service for tertiary service receivers

Partnership with local mental health professionals and volunteers

Based on the present service model, liaison with a network of local mental health professionals and volunteers were established via the provision of a series of training programme about psychological first aid and continuous education programme on various mental health topics. This liaison and training programme aimed at empowering existing helpers in the community for promoting mental health and offering psychological support in the local community through continuous education and exchanges with mental health experts from Hong Kong. The Psychological Health Education Series was organized in collaboration with the Critical Incident Team of the Division of Clinical Psychology, Hong Kong Psychological Society, for local professionals which included teachers, counselors and doctors. The education series which offered bi-monthly training opportunity for local professionals from June, 2009 to September, 2010 involved experienced clinical psychologists and psychiatrists from Hong Kong as instructors. The series consisted of different modules of mental health topics which included: (1) Psychological recovery after disaster, (2) Psychological health for adults, and (3) Psychological health for children and adolescents. Since the commencement of the Educational Series in June 2009, four training sessions have been offered with a record of 122 attendees. Topics covered under the first training module included "Psychological impact of disaster", "Psychological support for family with children with disabilities", "Crisis intervention" and "Sleeping problems".

Service for relief workers

Based on the "screen and treat" rationale, for local Red Cross relief workers in Chengdu, a one-session group sharing-cum-educational programme was provided to enhance their knowledge on normal stress response for disaster relief workers, self-care, and stress coping. Information on normalizing help-seeking and channels for receiving further psychological service were provided.

Conclusions

After the 5.12 Earthquake in Sichuan, mental health professionals in Hong Kong have involved in various types of support programmes aiming at enhancing psychological support for survivors at the disaster sites. These include provision of training to local professionals and volunteers, knowledge exchanges through visits, meetings and academic conferences. For example, exchanges between professionals from mainland China, Taiwan and Hong Kong on psychological relief work conducted after the earthquake in the 6th Joint Chinese Psychologists' Conference held in June 2008 in Hong Kong and in the 1st Joint International Conference of the Hong Kong College of Psychiatrists and the Royal College of Psychiatrists (UK) held in December 2008. There are training programmes for local helpers conducted by professionals from Hong Kong and overseas organized by the West China Hospital, Sichuan University (West China Hospital 2008). The present psychological service model developed for the Deyang Rehabilitation, Prosthetic and Orthotic Centre is probably a pioneer in the integration of expertise and experience between professionals in Hong Kong and Sichuan through a comprehensive service model and long-term co-operation between Hong Kong professionals and different levels of service personnel in the local community. Unlike previous psychological support services provided overseas after a disaster which involved professionals providing direct service to traumatized Hong Kong people (e.g., Lee, E. 2008; Lee, K. 2008; Wu 2005), this is probably the first time for mental health professionals in Hong Kong, clinical psychologists in particular, to be involved directly in the service development and delivery for local people at a disaster site outside of Hong Kong.

Based on the present review conducted one year after the psychological service had commenced, service implementation based on the model presented here was at an initial stage requiring further consolidation and development. The "screen and treat" approach has proven to be applicable and effective in identifying at-risk patients and their family caregivers. The use of standardized protocols in screening, particularly the verbally administered question-and-answer survey, are important for survivors who have limited literacy. On the other hand, the availability of standardized and validated self-report written measures is essential for establishing an empirical database in intervention and service planning. Moreover, self-report written measures may become more applicable as the opportunity for education improved for children.

Based on the results on standardized self-report measures, the percentage of patients found to have significant distress at least 6 months after the earthquake and associated risk factors identified provide important information for service planning. Present results show that 20–40% of adult and 10% of child patients requiring orthopaedic rehabilitation in the Centre indicated features of PTSD, anxiety or depression more than 6 months after the disaster. The relatively lower percentage of child patients found to have significant distress may suggest the resilience of child patients in adjusting to adversities when family and rehabilitation support are available because most of the child patients served in the Centre were accompanied by their family caregivers when receiving rehabilitation service in the Centre. However, it may also indicate that child patients tend to underreport their distress or the focus of screening utilized may not be adequate in terms of sensitivity and relevance in reflecting the distress experienced by children after the earthquake.

Results on the occurrence and risk factors for features of PTSD, anxiety and depression assist identification of at-risk adult and child patients for provision of early psychological intervention. Among the risks factors examined, higher perceived life threat, lower perceived emotional support and older age were identified as significant predictors of persistent psychological distress for both adult and child patients of the Centre. In addition, present results on risk factors suggest that the meaning of past trauma history may have different meaning for men and women, thus, contributing to higher distress for men but lower distress for women. Specifying the nature of past trauma in future investigation would help to increase our understanding on the gender difference identified for past history of trauma. Results on risk factors for adult and child patients suggest that there are both common and unique concerns for adults and children contributing to the development of psychological distress after natural disasters. Amputation was found to be significantly related to lower self-esteem for child patients confirming that body image plays an important role in the formation of self-image for children. This indicates that the adoption of a developmental perspective in service planning for disaster survivors is pivotal. The study on the occurrence and risk factors associated with psychological distress also requires further examination with a larger sample so as to increase the reliability and generalizability of the results.

The training programmes for local professionals have served as a platform for continuous exchange between professionals from Deyang and Hong Kong. However, the applicability of manual-based protocols and effectiveness of treatment offered are still to be proven. There are a number of challenges yet to be overcome for the development of psychological service in the Centre. Although a comprehensive service model, evidence-informed treatment programme manuals, and regular clinical supervision were available, service personnel providing direct service in the Centre are lacking of experience in service development and service provision for disaster survivors. Though the involvement of local counselors has helped to minimize gaps related to language barriers and cultural differences, psychological services are novel to the local people. Providing education to local people on psychological service and enhancing the operation flow of in-centre and outreach services, which involves the work of multi-disciplines, are among the fundamental things to be done for developing the psychological service of the Centre. Development of follow-up outreach service serving clients living in rural areas required clear treatment focus as well as flexible application of clinical skills for maintaining the standard of clinical service. Also, establishment of service-bridging channels and liaison work for local psychiatric service has still to be worked on for serving the severely disturbed patients of the Centre.

Note

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Part VI

Training

All truths are easy to understand once they are discovered; the point is to discover them.
– Galileo Galilei, 1564–1642

14

Educating for Life Adversities and Challenges:
Mainstreaming Trauma Training in University and Professional Training Curriculum

Catherine So-kum Tang

Current literature has revealed that people who have suffered psychological trauma are at increased risk for physical and mental health disorders (Kessler, Sonnega, Bromet, Hughes, and Nelson 1995; Norris et al. 2002). There is an increasing demand on the provision of immediate and long-term mental health services to direct victims of trauma as well as to indirect victims comprising family, friends, and community members who identify with the traumatic event. While practice guidelines and quick reference guides have been devised to insure the standard of care and treatment for traumatized individuals and communities (American Psychiatric Association 2004; Foa, Keane, and Friedman 2000), there is relatively little discussion regarding the teaching of trauma in academic and training settings. In Asia, courses on trauma training are not yet regarded as a core curriculum in professional training programmes in social work, counselling/clinical psychology, or psychiatry, although it is likely that almost all of these programmes will informally address psychological trauma and its treatment in their programmes. In this chapter, the author will discuss psychological trauma and its treatment as an emerging field of study, summarize international guidelines and standards for trauma training, identify evolving models of trauma training, and argue for mainstreaming the teaching of trauma in local university and professional training curriculum.

Trauma Psychology as an Emerging Field of Study

According to Figley (1988), a substantial and sustaining field of study can be identified by at least seven criteria. A field of study should have clearly defined historical roots, and is associated with an identifiable set of theories and concepts that will guide the growth of knowledge. With this foundation, research methods and data analysis, methods of assessment and measurement, and strategies for developing and testing effective intervention methods can emerge. There must also be at least one professional organization that represents the field as well as a set of publications that report contributions to the field. Lastly, a field of study should be capable of affecting policy and the judicial system.

According to the above defining criteria, there is evidence that the knowledge and treatment of crises, psychological trauma, and disaster has emerged as a new field of study as early as in the 1980s. Different names have been given to this field of study, including traumatic stress studies (Figley 1988), psychotraumatology (Everly and Lating 1995), traumatology (Figley 2003), and trauma psychology (Kendall-Tackett 2006). Throughout this chapter, the term "trauma psychology" will be used to represent this new field of study that focuses on understanding how and why people become traumatized, recover and thrive from the experience, and the best ways to facilitate such thriving. Many professional fields are represented in trauma psychology, including psychology, social work, psychiatry, mental health counselling, nursing, and other first responders and professions.

The first criterion for defining a field of study is its history. The clinical and scientific interest in psychological trauma has had a long history in Europe and has been further expanded in the United States during the 1970s in the wake of the Vietnam experience and modern feminism (Figley 1988; Weisaeth 2002). The rich and robust historical base of this new field of study can be traced back to the study of hysteria and traumatic neurosis of Oppenheim, Charcot, Janet, and Freud at the turn of the 20th century, of shell shock and war hysteria during the World War I, and of the Holocaust survivor syndrome, post-Vietnam War syndrome, and rape-trauma syndrome during the second half of the 20th century. Most agree that 1980 was a benchmark year in the study and treatment of psychological trauma when the American Psychiatric Association included posttraumatic stress disorder (PTSD) as an official diagnosis in the classification system of mental disorders. Today, trauma psychology has been extended to the study of interpersonal violence, health epidemics, medical adversity, road traffic accident, war and terrorism, and natural disaster: from the September 11 attack on the World Trade Center in the United States, to the global SARS epidemics, to political conflicts in the Gulf region and civil wars in Africa, and to the mega-earthquakes and its accompanying tsunami and natural disasters in Southeast Asia, Japan, and China.

The second criterion for a field of study is the existence of identifiable sets of theories, concepts, and measurements. Conceptual and theoretical formulations of trauma psychology are largely due to the work of Hans Selye and his notion of a General Adaptation Syndrome to stressful events and other theories of stress responding (e.g., Horowitz 1976). Prevailing trauma models and theories have typically focused on the extent to which traumatic events and experiences uniquely alter cognitive, emotional, and behavioural responses of traumatized individuals (e.g., Figley 1985; Janoff-Bulman 1992; Metcalfe and Jacobs 1996;

Saakvitne, Tennen, and Affleck 1998; van der Kolk, McFarlene, and Weisaeth 1996). More recently, a neuro-immuno-biological basis in the pathogenesis of PTSD that is different from common stress response and other mental disorders is also implicated (Lanius et al. 2001; Rauch, Shin, and Phelps 2006).

The real challenge for a field of study is to derive intervention strategies from the wealth of theoretical concepts and to verify their effectiveness following state-of-the-art outcome research methods. Current practice guidelines have listed specific psychopharmacological and psychological treatment strategies for acute and chronic PTSD (American Psychiatric Association 2004). In particular, there is compelling and consistent evidence demonstrating the efficacy of programmes of cognitive-behavioral therapy (CBT) in the management of patients with PTSD (Foa et al. 2000; Foa 2006). In particular, prolonged exposure to memories and situations associated with the trauma is found to be effective in reducing symptoms of PTSD, and its benefits remain apparent even after treatment programmes have finished.

Compared to other criteria for a field of study, relatively little has been discussed with regard to the extent to which the field has identified a substantive, specialized methodology, and data analysis. Current trauma research has relied heavily on standard epidemiological methods. There are discussions on ethics of interviewing victims, the use and misuse of archival data in estimating morbidity attributable to exposure to certain highly stressful events, the importance of establishing reliability and validity for measures of perception and appraisal, and the need to be culturally sensitive (Breslau 2004; Byrant and Njenga 2006; Hoshmand 2006; Wilson and Tang 2007). There is also an accumulation of research that investigates associations between brain structures/functions and PTSD symptoms, ranging from laboratory investigations of the animal model of PTSD to applications of structural and neuro-chemical imaging approaches for direct testing of specific hypotheses regarding neural substrates of PTSD symptoms of trauma patients in clinical settings (Lanius et al. 2001; Rauch et al. 2006; Tang 2007a). With the increasing interest on psychological trauma and PTSD, the number of publications and publishing countries has also increased significantly in recent years. However, these publications are still dominated qualitatively and quantitatively by developed countries and are mostly published in English (Bedard, Greif, and Buckley 2004; Figueira et al. 2007).

Various professional organizations that have a focus on trauma psychology have been formed in many nations. Among the first of such organizations is the International Society for Traumatic Stress Studies (ISTSS), which was founded in the United States in 1985 for professionals to share information about policy, programme, and service initiatives that seek to reduce traumatic stressors and their immediate and long-term consequences. Similar professional organizations have subsequently been formed in Africa, Australia and New Zealand, Argentina, Canada, France, Holland, Kuwait, Japan, and Hong Kong. Members of these societies typically include psychiatrists, psychologists, social workers, nurses, counselors, researchers, administrators, advocates, journalists, clergy, and others with an interest in the study and treatment of traumatic responses. There is also the new Division 56 on Trauma Psychology in the American Psychological Association, which was formed in 2006 to provide a forum for scientific research, professional and public education, and exchange of collegial support for professional activities related to traumatic stress.

In Asia, the interest in psychological trauma and PTSD has been mostly related to natural disaster, as a majority of Asian nations are situated on the "Circum-Pacific Seismic Belt" which has created several devastating earthquakes over past decades. In spite of the relatively short history of trauma psychology in Asia as compared to Europe and the United States, there is already an accumulation of relevant literature on Chinese (Tang 2007a), Japanese (Goto and Wilson 2003), and other Asian ethnic groups (Kokai, Fuji, Shinfuku, and Edwards 2004). In Hong Kong, this book volume documented the amount of local contributions on knowledge and practices of various trauma work conducted in a variety of settings (Wu, Tang, and Leung 2010). However, there are concerns regarding whether PTSD is a legitimate mental disorder category, whether Western instruments are valid assessment of this disorder, and whether basic assumptions of Western psychosocial trauma models and their treatment implications are applicable in Asian populations (Goto and Wilson 2003; Tang 2007b). The Japanese (JSTSS) and the Asian Societies for Traumatic Stress Studies (AsianSTSS) were founded in Japan in 2002 and in Hong Kong in 2005, respectively. These two professional organizations in Asia aim to advance the knowledge about the nature and consequences of highly stressful events and to provide a forum for exchange of theoretical formations, research, clinical strategies, and public policy about severe stress and trauma within the Asian region.

International Guidelines for Trauma Training

As described in previous sections, there is compelling evidence that trauma psychology has emerged as a new field of study globally and in Hong Kong. Given there is increasing public interest in trauma work, it is important to guard against any misuse or misapplication of the emerging knowledge in this area. As academic training programmes have the responsibility for developing training curriculum and selecting information from existing knowledge base, this new field of study should be verified by university preparatory programmes. Accreditation agencies also need to respond by including competence in trauma psychology as a requirement for professional training in relevant fields in clinical/counselling psychology, social work, psychiatry, etc. (Black 2006; Figley 2003; Hoshmand 2003; Saleh 1996).

Despite the emergence of trauma psychology as a new field of study for over two decades, there is relatively little discussion on its training models and core competence required of human service and mental health personnel who often engage in trauma work in their interaction with clients. On the other hand, there is considerable attention given to international trauma training when professionals travel from one international locale to another in response to large-scale disasters and crises (Bryant and Njenga 2006; Weine et al. 2002; Wilson and Tang 2007). This is related to the international obligation to provide a network structure to respond quickly to disasters by delivering services to trauma-exposed populations and to train local practitioners to respond optimally to trauma-related problems. While professionals might have been enthusiastic and altruistic in assisting traumatized populations and communities, they sometimes find themselves ill-prepared. The outcomes of their interventions and training were not always beneficial, and in many ways may have been hurtful. In fact, the Red Cross's World Disaster Report 2000 sharply criticized international mental health initiatives and issued an urgent call for standards to better structure relief efforts in large-scale disasters and crises (Walker and Walter 2000). Similar concerns were also echoed by the World Health Organization during the Southeast Asian earthquake and tsunami in 2004. Furthermore, individuals who have chosen to render services during disasters and crises are often not prepared for the emotional impact of disasters and the relief work on themselves. Working with victims of disasters and other traumatic events can have serious psychological effects for emergency personnel, relief workers, and mental health professionals, who may experience vicarious traumatization (Saakvitne and Pearlman 1996) and/or compassion fatigue (Figley 1995). Thus, it is essential to develop training programmes that can better equip relief workers and professionals with knowledge about treating trauma-exposed populations as well as heighten their awareness of the emotional burden involved in trauma work.

Recently, the International Society for Traumatic Stress Studies (ISTSS) has devised consensus-based guidelines for training personnel who are called upon to deliver psychosocial interventions for trauma-exposed populations in the international arena (Weine et al. 2002). The present author argues that these training guidelines are equally applicable to individuals and professionals who engage in trauma work in their own locale. ISTSS has affirmed that trauma training must be grounded in established scientific and clinical knowledge of trauma mental health and other related professional knowledge, address cultural dimensions, help recipients face both short- and long-term challenges, and have curriculum designed to fit the local situation. The following core elements are identified by ISTSS as essential in shaping the development and implementation of trauma training curriculum (Weine et al. 2002):

1. Training should include competence in listening and other communication skills to establish a sound helping relationship.
2. Training should cover assessment for proper recognition of psychosocial and mental health problems to avoid inappropriate diagnoses and interventions.
3. Training should include teaching of established and relatively mainstream, rather than highly alternative methods, to reduce distress.
4. Training should include the full understanding of the local context in order to determine the appropriateness and feasibility of specific interventions. Important considerations include help-seeking expectations, duration of treatment, attitude toward intervention, cost-effectiveness of the intervention, and family attitudes and involvement.
5. Training should provide strategies for problem solving and should not only be limited to treatment of stressor-induced symptoms or distress, but should also cover approaches to reduce problem situations whenever possible.
6. Training should include the treatment of medically unexplained somatic pain and to address the linking of psychosocial services to medical services in order to meet medical and mental health needs.
7. Training should include learning to collaborate with existing local human resources and change agents and to understand indigenous perceptions of suffering, illness, loss, pain, and healing. Collaboration with traditional healers is important because of their knowledge of and role in the community and the potential effectiveness of their interventions.
8. Training should ensure the establishment of an ongoing supervision structure, especially if paraprofessionals are trained to provide intervention. Training should also determine whether trainees retain the knowledge and skills obtained in the training to practice what they learned when competent supervisors are not available.
9. Training should cover self-care and encourage support among trainees to reduce vicarious traumatization or other forms of burnout.

International Standards for Trauma Training

In addition to these general guidelines for trauma training, the European Society for Traumatic Stress Studies (ESTSS 2004) has also proposed a basic architecture for trauma education for four groups of professionals who are likely to work with trauma-exposed populations. These four groups include emergency workers, primary health care providers, general psychiatrists and clinical psychologists, and trauma-specialized psychiatrists and clinical psychologists.

Emergency workers

Emergency workers include policemen, firemen, rescue workers, paramedics, and emergency room personnel. These professionals are often first responders to traumatic events as well as the first to interact with traumatized victims and their family, sometimes in catastrophic and chaotic situations. Training for emergency workers will focus on basic psychological first aid / crisis knowledge and skills. Their direct exposure to traumatic events also places them at high risk for burnout and vicarious traumatization.

The ESTSS proposes that accredited training programmes for emergency workers be comprised of 10 hours of knowledge module and 5 hours of practical skill module. The programmes should include knowledge of traumatic stress factors, critical incident stress reactions, preliminary signs of traumatic stress reactions in adults and children, information-giving techniques to concerned relatives, secondary trauma reactions and available support services, and media-management techniques. These professionals should demonstrate proficiency in psychological first aid techniques for both adults and children, as well as in connecting victims to various local support and resource networks for trauma-exposed populations.

Primary health care providers

Primary health care providers are general practitioners and pediatricians, who are often gatekeepers in making referrals to specialized psychiatric and psychological services. They are usually qualified social or health professionals who serve the general public. In some nations, nurse practitioners and social workers may also be appropriate candidates for this training level. They are likely to see early trauma and stress reactions, which have not yet become noted. Primary health care providers are also likely to encounter victims of domestic violence and child abuse in the course of general practice.

Accredited training programmes for these professionals should comprise of 8 hours of knowledge module and 2 hours of practical skill module. The contents include knowledge of behavioural and clinical signs of victimization (e.g., child abuse, domestic violence, sexual assault, or torture, etc.), local laws and ethical guidelines concerning victim abuse issues (e.g., child abuse reporting), risk factors and clinical signs of acute and chronic PTSD, and other trauma-related disorders in children and adults. These professionals should demonstrate proficiency in psychological aid techniques for both adults and children and in connecting victims to local support and resource networks.

Secondary health-care providers

According to ESTSS, general clinical psychologists and psychiatrists belong to secondary health-care providers in trauma work. Given that 2–15% of the general population suffers from trauma-related disorders (Breslau, Davis, Andreski, and Peterson 1991; Kessler et al. 1995), these mental health professionals should have a working knowledge of trauma psychology and be able to evaluate as well as to treat a range of simple trauma disorders. They should be competent to provide appropriate referrals to both victim assistance networks and specialized psycho-trauma centers. Ideally, trauma training should form part of the general training curriculum in psychiatry and clinical psychology study programmes. Alternatively, it may also be taught as a continuing education requirement for these professionals.

Accredited trauma training of secondary health care providers should comprise 40 hours, most of which can be woven into existing university lectures and practicum. It should include theory, assessment, and treatment models of psychological trauma. The theory module includes knowledge of the biological, psychological, social, and cultural implications of trauma; cultural, anthropological, and gender issues related to trauma; child development issues related to trauma; effects of exposure to traumatic events throughout the life span; relationship between trauma and memory; and transgenerational issues related to traumatic events. The assessment module includes knowledge of diagnostic criteria such as ICD-10 and DSM-IV for the full range of trauma disorders (e.g., acute and chronic PTSD, dissociative disorders, personality disorders, etc.), comorbid trauma-related disorders (e.g., substance abuse, depression, panic disorder, eating disorder, brief reactive psychosis), somatic symptoms (e.g., hyperventilation) and psychosomatic disorders related to trauma exposure (e.g., high blood pressure, stomach ulcers, etc.). These professionals should also be taught about pathogenic factors (e.g., bio-psychological vulnerability) and salutogenic factors (e.g., social support) in trauma-exposed individuals, knowledge of national laws and ethical guidelines concerning victims issues (e.g., child abuse reporting, political asylum demand process, etc.), and knowledge of legal and clinical issues particular to victimized women and children (e.g., child placement, battered women socio-legal programmes, etc.). These professionals also need to demonstrate competence in simple treatment skills including psychological and pharmacological methods for early stress reactions and simple PTSD among children and adults, and proficiency in linking patients to socio-legal victim assistance networks including general crime, war, and disaster victim agencies, domestic violence and rape assistance programmes, as well as child protection programmes. In order to enhance learning related to trauma and victim issues, clinical practicum should include in vivo or video observation of at least two trauma victims in a natural setting (e.g., at emergency rooms), assessment and diagnoses of at least one trauma victim under supervision, and treatment or observation of treatment of at least one adult and one child trauma victim under supervision.

Tertiary mental health-care providers

Trauma-specialized clinical psychologists and psychiatrists belong to tertiary mental health providers. Trauma training is provided at the post-graduate or post-qualification level, and includes competency in all knowledge required of the previous three groups as well as advanced training in advanced theory, assessment, and treatment modules. Trauma training for these specialized professionals is comprised of 240 hours of course work plus 160 hours of practicum. Learning will be evaluated via a standardized written examination, oral examination, and supervisor assessment. Specialized training can be coordinated by existing trauma clinic in conjunction with national universities and teaching hospitals.

The course work contents include not only advanced theory and assessment modules, there is also advanced training on complex treatment skills such as conceptual and practical proficiency in the utilization of at least two evidenced-based trauma symptom reduction techniques (e.g., exposure techniques, cognitive restructuring, relaxation, etc.), in generating appropriate reports and certificates concerning victims' psychological status for legal and social systems, in treating at least two trauma areas (e.g., war, refugees, sexual abuse, physical abuse, terrorism, transportation accidents, natural disasters, etc.), in coordinating patient network linked to various socio-legal victim assistance or protection programmes, and in recognition and management of secondary traumatization processes among psychiatrists and clinical psychologists which may counteract treatment. To enhance learning, these programmes should include a practicum in which participants have experiences of assessing and making diagnosis of at least six victims in conjunction with 6 hours of supervision, and performing at least 100 hours of therapy in conjunction with 40 hours of individual supervision with at least eight cases presenting at least two different types of traumatic situations.

Models of Trauma Training

Models of trauma training are still evolving, even in the Western context. For example, in Sweden, it is insisted that psychiatric interns should treat at least one victim presenting a trauma-related disorder under supervision during their medical residency. However, in other European or North American nations, there is no standardized trauma training for either psychiatry or clinical psychology students. Various universities throughout Europe and America do include courses on trauma in clinical psychology studies, but these tend to be exceptions. As no accredited standard exists in the field of trauma psychology, it is not possible to monitor the quality of training nor its upkeep with research and theoretical developments in the effective treatment of traumatized individuals.

Globally, there are at least five modes of delivering trauma education. The most vigorous mode is comparable to that of the scientist-practitioner model of training in clinical psychology. It includes a systematic programme of study at the post-graduate and post-qualification level, with an emphasis on theory, practice, and research of psychological trauma and its treatment. Given trauma psychology is a relatively new field of study, time is needed for it to gain acceptance and recognition as a distinctive academic programme in academic training institutions and universities. Thus, there are few training programmes that offer advanced academic degree programmes in trauma psychology.

An alternative model is to deliver trauma education as a modular or subspecialty training embedded in existing professional training programmes in relevant fields such as clinical psychology, counselling, and psychiatry. This seems a viable alternative model of trauma training that can also meet international standards (ESTSS 2004). Indeed, there is an increasing number of professional training programmes including specific aspects of trauma psychology (e.g., disaster management, sexual trauma, child/family therapy and trauma, etc.) as a specialist module in their training curriculum.

Due to various reasons, some nations may not be in a position to provide specialized trauma training in their existing professional training programmes. It is thus probably more practical to provide continuing education in the form of certificate programmes and workshops for practitioners who are already in human and mental health services. Currently, the most common mode of trauma education is through one- or two-day workshops on specific aspects of trauma psychology, mostly on treatment approaches to specific trauma. Many argue that as the field advances, this fast-track approach to trauma training will no longer be acceptable to professional communities and the public (Figley 2003).

For nations that have limited training resources, it will be more realistic to work toward making the training of related professionals more trauma-informed (Harris and Fallot 2001; Hoshmand 2006) by incorporating basic knowledge of trauma and its treatment in existing professional training curriculum. There are yet other nations, mostly developing nations, which may not even have in place systematic health and mental health training programmes. It is only in times of severe disasters and crises that foreign trauma experts travel to these nations to train local relief workers or practitioners.

Trauma Training in North America and Europe

The trauma training programme which originated from the Florida State University Psychosocial Stress Program in the United States is an example in reflecting the evolvement of various training models and practice standards for trauma work (Figley 2003). This training programme emerged in 1996 as a response to one of the worst acts of domestic terrorism in the United States, the Oklahoma City bombing in 1995. In assessing and treating fellow citizens of Oklahoma, mental health professionals wanted more in-depth knowledge of the history, theories, and research supporting intervention approaches; skills of assessment, diagnosis, and treatment of trauma-related symptoms and syndromes; and necessary competency to apply this knowledge and skill with traumatized individuals under proper supervision. To meet these expectations of knowledge, skill, and competency, the Registered Traumatologist Program (the Program) was born with the support of grants from the Florida State University. Students of the Program had to complete five trauma-related courses, including orientation to trauma, orientation to clinical traumatology, skills in one of the approved treatment approaches, contextual applications, and supervised practice. The Program received good responses from local professionals as well as those from Canada, Europe, Africa, South America, Australia, and New Zealand.

The Traumatology Institute emerged in 1998 to become the training organization of the Program. The Registered Traumatologist was also replaced with the designation of Certified Traumatologist based on market research and legal review. In recognition of different needs of non-mental health professionals such as nurses, first responders, journalists, teachers, and others, the Institute also established the Field Traumatologist certification which requires the completion of a course on the proper orientation to the field, especially crisis intervention, knowledge and skills of crisis intervention methods, as well as a thorough awareness of the incident command structure and other information critical for helping traumatized individuals. Those acquiring Certified Traumatologist certification complete the orientation course and four other courses on expertise and competence in at least one trauma treatment, as well as receive 20 hours of individual supervision in working with traumatized victims. The Institute also approves and accredits other training institutes to offer the same five courses. By 2002, there were more than a dozen affiliated traumatology teaching institutes in South Africa, Canada, Mexico, Puerto Rico, and throughout the United States. The advantage and strength of this innovation was that more people had further access to the standard curriculum that is now taught by local teachers who could also coordinate or provide supervision for clinical experience.

In 2003, the Traumatology Institute moved the Certification Program to a private certifying body, the Academy of Traumatology. The Commission on Certification and Accreditation was formed within the Academy to provide guidance to current and proposed traumatology teaching institutes which wished to become accredited. Currently, the Academy sanctions the certification of 1) Field Traumatologist, with competency in offering psychological first aid and other emergency mental health services, 2) Certified Traumatologist, with competency in clinical traumatology services including trauma-informed, culturally-competent assessment and treatment of individuals, families, groups, and communities exposed to traumatic events, 3) Certified Compassion Fatigue Educator, with competency in assessing and preventing distress related to trauma work with an emphasis on self-care, and 4) Certified Compassion Fatigue Therapist, with competency in assessing and treating service providers and volunteers traumatized by their work with trauma victims.

Similar multi-model trauma training institutes are increasing in the United States, such as the Trauma Program of the National Institute for the Psychotherapies Training Institute in New York, the Trauma Training Program of the Justice Resource Institute in Massachusetts, and the International Trauma Studies Program in the School of Public Health at Columbia University in New York.

Globally, trauma training institutes have also been established, generally of a much smaller scale than those found in the United States. For example, the Psychotraumatology Institute Europe (PIE) was established to provide continuing education and research on trauma. It invites experts from Europe and other continents to deliver cutting-edge presentations, workshops, and courses regarding the assessment and treatment of chronic traumatic stress responses. It also initiates and supports research of chronic trauma as well as trauma-related dissociative disorders.

Trauma Training in Hong Kong

Compared to some Asian nations, Hong Kong has relatively well-established academic training programmes for mental health professionals (e.g., psychiatrists, psychiatric nurses, and clinical psychologists) on etiologies, diagnosis, and treatment of psychiatric disorders. However, courses on trauma training are typically not included as a core curriculum in these programmes, although almost all of these programmes address trauma-related issues informally, as in stress and coping, crises management, grief and bereavement, etc.

In 2005, an innovative university-based two-year part-time master degree programme on Trauma Psychology was launched in response to the global development of this new field of study. The objective of this programme is to provide post-graduate training to human-service and health-care professionals (such as social workers, human resource managers, psychologists, and other mental health personnel) with basic understanding of current theories and evidence-based applications of psychological approaches in trauma work. Students of this programme are required to complete a total of 24 units of course work and two units of independent research. There are two foundation courses on adjustment and trauma management. The core curriculum of this programme includes two trauma modules, which can also be studied separately and independently, resulting in an award of a postgraduate diploma. The Life Adversity and Social Trauma module includes current knowledge on theories and practices about exposure and reactions to physical and psychological adversities, life trajectory adversities, and social adversities such as interpersonal violence, victimization, terrorism, and natural disaster. The Family Trauma module includes current knowledge on theories and practices about intra-familial child abuse, intimate partner violence, and elder abuse.

Since its inception, the public and professional reception of the new trauma programme has been encouraging. There was also a plan to further extend trauma training to a doctoral-level specialist training. It was proposed that graduates of the master-level trauma programme would be eligible to apply for the doctoral programme to become trauma specialists who are required to complete advanced trauma training on practicum and supervised practice. However, due to a change of resource allocation to various fields of study within the academic department, the master-level trauma programme was phased out in 2009. In the meantime, the AsianSTSS continues to fill in the local training gap by organizing and offering trauma-related seminars and workshops to interested professionals. Figley (2003) has cogently pointed out that as the knowledge and practice of trauma work advances globally, professionals will need and demand a systematic programme of study, rather than weekend workshops. In view of the global interest and demand on systematic trauma training, it is very likely that a programme of study on trauma psychology may be offered again by local academic and training institutions in coming years.

Mainstreaming Trauma Training in Hong Kong

At present, Hong Kong and a majority of Asian nations do not yet have the academic support or resources for a distinctive academic programme in trauma psychology, nor have in place private or non-profit training institutes for specialized mental health training. Thus, it may be more feasible and viable to work toward ensuring students and professionals in related fields in Hong Kong to become more trauma-informed (Harris and Fallot 2001; Hoshmand 2006). The present author proposes that trauma education in Hong Kong be included in all levels of university and professional training curriculum of clinical psychology, psychiatry, mental health counselling, social work, and nursing, etc. As such, trauma training is treated as a mainstream curriculum in Hong Kong, rather than as an elective module or as a post-qualification specialization. The exact content of the trauma curriculum will depend on the level of academic and professional training in related fields. Knowledge about basic concepts and application approaches can be introduced at the undergraduate or pre-qualification level, while advanced theories, research, and intervention methods can be taught during graduate or professional training of related fields of study.

In applying the mainstreaming model of trauma education in Hong Kong, the field of psychology will be used as an example, given the academic training of professional psychology is still evolving. At the undergraduate and pre-qualification level, a course such as the Introduction to Trauma Psychology will be offered to all students. This course will provide the foundational academic training to students about the cutting-edge knowledge of psychological trauma and its treatment implications as well as stimulate students' academic and research interest in trauma psychology. In particular, this course will provide an overview of psychological impact of critical life events and life adversities, abnormal human responses, as well as resilient functioning in psychological trauma, current trauma management and intervention strategies, and acute and chronic stress reactions to specific psychological trauma such as death of loved one, sexual victimization, abuse, domestic violence, war, and natural disaster. For graduate professional training in clinical psychology, the course work and practicum requirements for general or master-degree clinicians will be re-aligned in accordance with the ESTSS standards of trauma training for secondary health-care providers, while curriculum for doctoral-level training in clinical psychology will make reference to the ESTSS standards for training tertiary mental health care providers who are specialized in trauma work.

Attempts to mainstream trauma training in local universities are evident in recent years. For example, an introductory level undergraduate course on "Psychology of trauma and disaster" has been offered in the University of Hong Kong in 2008 and 2009. This course provides a broad overview into the research knowledge and psychological management practices in handling individual and community trauma. Students are expected to gain an understanding of post-traumatic illnesses and growth, psychological aftermath of various traumatic events such as road traffic accidents, natural disasters, crime victimization, family violence, war and terrorism, exposure to sudden death and life threatening illnesses, as well as issues regarding to the identification, intervention, and management of trauma and disasters. A special feature of the course is that students are also required to engage in an in-class practical training session in psychological first aid.

Vicarious Traumatization and Trauma Training

McCammon (1995) has cautioned that trauma training is a painful type of pedagogy, as it results in teachers and students "being sadder but wiser". Students are vulnerable to experience vicarious trauma when they have unresolved emotional issues relating to the inevitable exposure to traumatic material in learning how to treat psychological trauma. The exposure may occur through examination of clinical case examples, watching classroom videos, receiving client disclosure, reading assigned materials, or engaging in classroom discussions. Indeed, research has shown that even in introductory psychology courses, about 84% of nonclinical undergraduate students reported at least one traumatic experience of sufficient intensity to elicit PTSD (Vrana and Lauterback 1994). Thus, it is important that trauma training does not increase the risk of students becoming vicariously traumatized by course contents.

McCammon (1995) and Black (2006) have listed ten suggestions to prevent undue distress in students attending a class or course that addresses issues of trauma. These suggestions include: establishing an accepting, but not confessional, tone for the class, informing students regarding topics to be covered in class, gauging the level of emotional intensity of teaching materials, providing information regarding counselling and support resources both on and off campus, speaking privately with students who are required to disclose in class, relating personal disclosures in class to the course content, providing information regarding self-help literature, including a discussion about treatment for trauma, implementing a debriefing session following intense classroom discussions, and assessing students' potential for vicarious traumatization.

Black (2006) has described a new six-week university-based graduate course on trauma counselling in Canada with the course curriculum designed to prevent students from feeling overwhelmed by the traumatic material in the course, while providing meta-teaching opportunities about how to approach traumatic material with clients. Teachers of trauma-related courses in professional training programmes in Hong Kong should also take note of this approach, as anecdotal evidence suggested that students attended this special course did not experience themselves as being overwhelmed during the course even though a fairly heavy amount of exposure to traumatic material was introduced. Specifically, this special class focused on trauma treatment based on principles of resourcing, titration, and reciprocal inhibition. It was a small class with 15 graduate students and the general format included lectures, discussions, critical reflections, group presentations, and the submission of scholarly papers on topics related to trauma. The class met twice a week for a period of six weeks. Students in this course had already completed at least one year of graduate training and education in counselling, including theoretical and practicum-based courses as well as instruction on self-care. In the trauma course, students were informed about their right to engage with traumatic material to their level of comfort and were given control about how much they exposed themselves to traumatic material during the course. They were also encouraged to disengage with the material (i.e., leaving class, turning their heads away from the video screen) if they felt they needed a break from the exposure. Trauma materials were introduced in small manageable "doses" and incorporating deep breathing exercises at the beginning, middle, and end of the class to demonstrate to students the ability to pair relaxation with exposure to traumatic material such that they were not overwhelmed during the course.

Conclusion

The knowledge about the impact of psychological trauma and its treatment has emerged as a new field of study globally and in Hong Kong. There are international guidelines and standards to guide the training of various levels of personnel who are likely to engage in trauma work. Models of trauma training are still evolving, and there is no available mechanism to evaluate which of these models is optimal. Hong Kong and a majority of Asian nations do not yet have the academic support or resources for a distinctive study programme in trauma psychology, and courses on trauma training are typically not regarded as a core curriculum for training mental health professionals. The author argues that professional training programmes in psychology, psychiatry, counselling, and social work in Hong Kong should strive to become more trauma-informed to enable professionals in these fields to keep abreast of the latest development in trauma psychology, to acquire competency in treating traumatized populations, and to guard against any misuse or misapplication of the emerging knowledge about psychological trauma and its treatment. Trauma education in Hong Kong should become a mainstream subject in university curriculum and professional training in related fields so that trauma knowledge can permeate all levels of training. It is through mainstreaming of trauma training in related professions that the standard of care and treatment for traumatized individuals and communities can be insured.

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Part VII

Closing

Don’t believe what your eyes are telling you. All they show is limitation. Look with your understanding, find out what you already know, and you’ll see the way to fly.
– Richard Bach, 1936–

15

Action Before Trauma:
Reflections on Psychological Trauma

Eugenie Y. Leung

With the advent of the concept of PTSD, people become aware of the potential risk and long-term psychological impact arising from traumatic experiences. Researchers and practitioners have focused their attention on a wide range of trauma stressors such as military combat, terrorist attack, torture, being taken hostage, natural or manmade disasters, violent personal assault, serious accidents, learning about sudden, unexpected death or life-threatening disease. In this volume, we have witnessed the development of trauma psychology in Hong Kong in terms of identification, treatment and prevention. We will continue to work on improving our knowledge in trauma, sharpening our assessment tools, using only evidence-supported or evidence-informed intervention strategies. At the same time we will work on providing prompt support and intervention as the earliest possible time after the trauma event occurs, developing specialization and specialty programmes at university levels, initiating large-scale community awareness education and effecting government attention to trauma-related issues in public policy and public services. Nevertheless, there are still lots of challenges and directions for further development in this field.

One of the major challenges comes from the increased media attention and public knowledge of psychological impact of trauma. It is commonplace nowadays for the media to approach social service or mental health professionals to enquire into the potential psychological impact on the victims and the service provisions whenever any traumatic event occurs locally, regionally or internationally, e.g., major traffic accidents, the South Asian Tsunami (2004), the Sichuan Earthquake (2008), and the Swine Flu outbreak (2009). Service providers somehow felt a “duty to intervene” when such massive and sensational disasters occur. Therefore, small- and large-scale social service agencies, universities and professional bodies, whether out of altruistic motives or corporate image motives, flocked to the scene and offered their assistance, advice and training. Everybody talks about “therapy fatigue” experienced by the victims and the local service providers — within weeks and months after the trauma, victims have been repeatedly asked by different groups of caring helpers to talk about or draw their trauma experience, and local service providers have repeatedly attended training provided specialists from all over the world on similar topics or with totally contradictory messages. And yet, everyone is still doing the same tasks with the assumption that their approach works best for their target recipients. This reflects the need for trauma professionals to rationally strike a balance between the goodwill to intervene or educate and the duty to do no harm. At the crisis stage, and when confronted with cries for help, helping professionals might be too overwhelmed with the obligation to help to the extent of overlooking the risk and harm of over-intervention and inappropriate intervention. Preparedness is probably the most important dimension that trauma workers need. This includes developing and implementing some rational, stepwise, systematic and sustainable model of intervention and education during peaceful times instead of doing it on an ad hoc basis and as a knee-jerk reaction to crises and pressing external demands. Some of the contributors in this volume have already pointed out the importance of incorporating trauma work into the existing disaster contingency and crisis management system, and even broadening into the crime investigation and public health arena.

Similarly, when personal trauma occurs, we should be cognizant of potential victim-making (Dileen 1999) by pathologizing people in abnormal situations into abnormal people, labelling all victims "damaged", "wounded", "abused", "traumatized", incapable of coping or overcoming these experiences. Detailed description of PTSD as typical reactions and talking about the damage of not seeking immediate intervention can run the risk of labelling the unwounded as untreated victims, normality as denial and repression, overlooking their capacity for resilient coping and self-healing, and the danger of overgeneralizing and over-pathologizing even in relatively minor trauma incidents. Therefore, in media interviews and public education, the focus should not be purely on the type of trauma stressors, but more on the core components such as characteristics of the traumatic exposure (such as frequency, chronicity, the extent of warning, severity and during of the event) as well as diversities in human experience (such as perceived helplessness, terror and fear, individual preparedness, coping strategies, vulnerabilities, resilience, potential for growth) instead of the one-size-fits-all prediction of psychological sequelae. Stereotyping all those who have encountered the trauma stressor into a common victim-and-patient image is as problematic and harmful as the trauma stressor itself.

Another challenge in trauma rests in the fact that a lot of traumatic experiences do not come from sudden time-limited events such as natural disaster and assault but from everyday experiences such as discrimination and threats to psychological integrity. Verbal bullying, cyberbullying, emotional abuse and neglect may not be a threat to physical integrity, but are emotionally distressing and traumatizing to self-image, self-esteem and the social self. Present-day discrimination is more subtle and is still based on race, ethnicity, religion, gender, sexual orientation, physique, age, disability etc.. Such prejudice and discrimination give victims a feeling that they have less control over their lives as such experience happens everyday, anywhere, anytime. Secondary victimization is also more prominent as the psychological effects of such bias-motivated hostility are not only found in the victims but also on members of the victim's group (McDevitt et al. 2001). People who are bullied, neglected, or discriminated, or witness these happening to their reference groups, constantly live in a state of heightened alertness, fear, terror and helplessness, and since such emotional experiences are chronic and hidden, it is likely to be underestimated, under-recognized and under-treated. And yet, even if these are identified, victims and therapists find these more difficult to manage than other trauma experience because it is almost impossible to remove the victims from its stressors as discrimination and prejudice are ingrained in the culture and values of the community the victims live in. This author hopes that trauma researchers and therapists will not ignore the developmental and sociopsychological effects of such ongoing traumatogenic experiences.

The third and probably greatest challenge comes from values and culture and a need for social reform and social action. Central to traumatic stress are powerlessness, uncontrollability, helplessness, and threats to one's life and safety. The simple logic about the best way to eradicate trauma is to work on those events causing trauma such as wars, disasters, abuses, and violence. The ultimate goal of trauma psychology should be towards making the world a better place where there is no war, no discrimination, no abuse or exploitation, building a cohesive family and harmonious community etc. In order to move towards these directions, we have to start with a realistic and pragmatic level of understanding and changing victims' sense of self and their perception of their social world. We need to critically review our cultural core values and beliefs, as they have strong influence on how we make sense of the trauma experience and evaluate ourselves and our world. For instance, rigid and dogmatic adherence to cultural values of family cohesion and morality can increase victim-blaming and conspiracy of silence: "keeping the family intact at all cost" is the value underlying the non-disclosure of intrafamilial abuse, "a bad relationship is better and less shameful than no relationship" is the belief for a victim's reluctance to leave an abusive partner, and cultural values of seeing female rape victims as "damaged goods" is central to guilt and shame expressed by such victims. One way of alleviating such undue blame and guilt is to encourage critical examination of the cultural values. Empowering the victims to analyze the cultural assumptions and to strike a balance by examining self-determination and victim's rights is an important component in treatment. But again, it is better to take action in changing and challenging the flip side of our cultural values, and especially the underlying sexist biases and double standards, before they colour the victims' experience of the traumatic event. It is only when our culture acknowledges egalitarian rights and mutual respect within the family and between genders that guilt and blame may eventually disappear from the list of posttraumatic symptoms.

It is said that the best prevention of natural and technological disasters lies in paying attention to the root causes such as climate change, deforestation, global warming, sustainability, industrial safety, respect for human lives, and corruption. In the same vein, the best way to prevent trauma related to war and terrorism is to address the fundamental issues of peacebuilding, respect for human rights and human diversity, intergroup communication, meeting the psychological and physical needs of the minority group members and respecting their cultural worldviews, and raising a generation of inclusively caring children. Interested readers can refer to Borum (2004) and Stout (2004) for their views and suggestions.

In 1982, Albee advocated that more widespread and expensive social reform is needed to prevent, rather than just treat, the emotional distress and mental disturbance in our society, which is due to dehumanizing social influences, such as oppression, racism, and sexism. With the same ethos, it is time for trauma psychology to focus not only on early identification and treatment of, and recovery from, psychological and social aftermath of trauma, but also on primary prevention and social reform, from a clinical psychopathological perspective to a community psychology framework of locating the mental health threats in the social environment and using psychology knowledge to resolve such social problems. This is the place where practitioners and researchers should go out of comfort zones of our armchairs and offices, apply our psychological knowledge and expertise in understanding trauma, critically review our values, roles, and system, calling for action that go directly to the root causes of the problem, act on our social responsibilities and build a trauma-free world with a culture of social justice. Though some contributors in this volume are already questioning our own roles, power issues, political and social agenda, and going from the individual work towards policies and social change, it is still a long journey less travelled. To conclude, actions towards changing and challenging the root of trauma are important, if not better, strategies in alleviating or even eradicating trauma experiences in humankind.

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Appendix A

Chinese version of Impact of Event Scale — Revised (IES-R)

姓名：____________________ 日期：________________ 檔案號碼：_______

事件影響測量表——修定版

以下是一些人經歷過壓力事件後會經驗的困難。請細閱每一項目，並按自己過去七天的經驗選擇最能夠形容每一項困難對你影響的程度。以下提到的[那件事]是指：___________________有關經歷。

	完全沒有	少許	中度	相當大	極度	
1. 任何有關那件事的事物也會引起我對那件事的感覺						I
2. 我難於保持安睡						I
3. 其他事情不停地令我想起那件事						I
4. 我覺得煩躁和忿怒						H
5. 每當我想起那件事或者有其他事物令我想起那件事時，我會盡力避免讓自己心煩意亂						A
6. 我會無意中想起那件事						I
7. 我覺得那件事好像從未發生過或並非真實						A
8. 我避開一些會令我回憶起那件事的事物						A
9. 關於那件事的影象在我腦海中突然浮現出來						I
10. 我神經過敏及容易被嚇得跳起來						H
11. 我嘗試不想起那件事						A

下接第2頁

	完全沒有	少許	中度	相當大	極度	
12. 我察覺到我仍然對那件事有很多感受，但我沒有去處理它們						A
13. 我對那件事的感覺是有點兒麻木						A
14. 我覺得我的行動或者感覺好像回復到那件事發生時的行動和感覺一樣						I
15. 我難於入睡						H
16. 我對那件事的強烈感覺一陣一陣地湧現出來						I
17. 我嘗試忘記那件事						A
18. 我難於集中精神						H
19. 令我想起那件事的事物使我身體產生反應，例如：流汗、呼吸困難、作嘔、或者強烈心跳						H
20. 我夢到那件事						I
21. 我覺得自己警覺性很高，處處提防						H
22. 我嘗試不談論有關那件事的話題						A

I	A	H

Impact of Event-Scale Revised. Reprinted with permission from Weiss, D. S. and Marmar, C. R. 保留所有權利。本測驗中文版由 Wu, K. K., & Chan, K. S. 翻譯。中文版 Copyright © 2001 by Wu, K. K., & Chan, K. S. 經許可翻譯複印。

Appendix B

Chinese version of Posttraumatic Stress Disorder Checklist (PCL)

創傷後壓力症量表

以下是一些人在經歷了壓力事故後會出現的問題。請細閱每一項目，然後在右方選上適當的數字代表你在過去一個月被該問題困擾的程度。

你所經歷的那件事是發生於___年___月___日的_______________（事情）。

	完全沒有	少許	中度	相當大	極度	
1. 有關該壓力事故的回憶、思想、或影像重複地出現並且帶來困擾？	1	2	3	4	5	R
2. 有關該壓力事故的夢境重複出現並且帶來困擾？	1	2	3	4	5	R
3. 突然地表現得或感覺到彷彿該壓力事故再次重演一樣（彷如再次身歷其境）?	1	2	3	4	5	R
4. 當有些事情令你想起該壓力事故時會感到十分不安？	1	2	3	4	5	R
5. 當有些事情令你想起該壓力事故時便會出現生理反應（例如：心臟厲害地跳動、呼吸困難、冒汗）？	1	2	3	4	5	R
6. 避免想起或談及該壓力事故或有關的感覺？	1	2	3	4	5	A
7. 避免某些活動或場合因為它們會令你想起該壓力事故？	1	2	3	4	5	A
8. 難於記起該壓力事故的重要環節？	1	2	3	4	5	A
9. 對從前喜歡的活動失去興趣？	1	2	3	4	5	A
10. 感到與其他人有所距離或隔膜？	1	2	3	4	5	A
11. 覺得感情麻木或不能對親密的人有愛的感覺？	1	2	3	4	5	A

下接第2頁

	完全沒有	少許	中度	相當大	極度	
12. 感到你的將來彷彿會提早終結？	1	2	3	4	5	A
13. 難於入睡或保持安睡？	1	2	3	4	5	H
14. 感到煩燥或有大發雷霆的情況？	1	2	3	4	5	H
15. 難於集中精神？	1	2	3	4	5	H
16. 處於「極度警覺」、提防或戒備的狀態？	1	2	3	4	5	H
17. 感到神經過敏或容易受到驚嚇？	1	2	3	4	5	H

R	A	H

Posttraumatic Stress Disorder Checklist. Reprinted with permission from National Center for Posttraumatic Stress Disorder (NCPTSD) 保留所有權利。中文版由 Wu, K. K., & Chan, K. S. (2002) 翻譯。 經美國 NCPTSD 許可翻譯複印。

Appendix C

Chinese version of Life Event Checklist for Clinician-Administered PTSD Scale for DSM-IV (CAPS-DX)

Please observe users qualifications and training required for conducting CAPS-DX.

Training information and CAPS manual is available for qualified users from the National Centre for PTSD

由臨床專業施行的 DSM-IV 創傷後壓力症量表 (CAPS-DX)
之人生經歷檢核表中文版
Chinese version of Life Event Checklist for Clinician-Administered PTSD Scale for DSM-IV (CAPS-DX)

請注意實施此量表的使用者資格及所須訓練

合資格的使用者可向 National Centre for PTSD 索取有關訓練的資料及 CAPS 的手冊

人生經歷檢核表

以下是人生歷程中一些有時會發生的困難或壓力事情。請細閱每項事情，並在右邊一個或多個的方格內加上✓號以表示：(a) **這件事曾經發生在你個人身上**，(b) **你曾經目睹這件事發生在別人身上**，(c) **你知道這件事發生在你親近的人身上**，(d) **你不肯定對這件事的答案或** (e) **這件事在你身上不適用**。

請記著，在你填寫下表時，請你回顧整個人生經驗（包括你童年的成長和長大後各項經歷）來回答。

事件	**曾經發生在你身上**	**曾經目睹**	**知道這件事**	**不肯定**	**不適用**
1. 大自然的災難（例如：水災，颶風，龍捲風，地震）					
2. 火災或爆炸					
3. 交通意外（包括車輛，船隻，火車或飛機的意外）					
4. 工作中，娛樂活動中或在家居發生的嚴重意外					
5. 接觸有毒物品（如危險化學物質，幅射等）					
6. 暴力襲擊（如被人毆打，拳打腳踢，猛力掌摑等）					
7. 以武器攻擊（如被槍擊，刺傷，被人持刀，持槍或以炸彈恐嚇等）					
8. 性暴力（如意圖強姦，以武力或恐嚇要脅進行任何與性有關的活動）					
9. 其他不自願情況下的性經驗					
10. 參與戰事或身處發生戰爭的地方（不論是作為平民或參與軍事工作）					
11. 被禁錮（如被綁架，拐走，被脅持作人質，在戰事中被監禁或俘虜等）					
12. 威脅生命的重病或重傷					
13. 重大的人生苦難					

14. 突然涉及暴力的死亡（包括謀殺和自殺）					
15. 與你親近的人突然死亡					
16. 你導致別人嚴重受傷或死亡					
17. 任何其他難以面對和處理，使你有很大壓力的經歷					

Life Event Checklist for Clinician-Administered PTSD Scale for DSM-IV (CAPS-DX). Reprinted with permission from National Center of Posttraumatic Stress Disorder (NCPTSD) 保留所有權利。中文版由 Wu, K. K., & Chu, L. Y. (2004) 翻譯。經美國 NCPTSD 許可翻譯複印。

Appendix D

Chinese Version of Clinician-Administered PTSD Scale for DSM-IV (CAPS-DX)

Please observe users qualifications and training required for conducting CAPS-DX.

Training information and CAPS manual is available for qualified users from the National Centre for PTSD

由臨床專業施行的 DSM-IV 創傷後壓力症量表中文版 (CAPS-DX) Chinese version of Clinician-Administered PTSD Scale for DSM-IV (CAPS-DX)

請注意實施此量表的使用者資格及所須訓練

合資格的使用者可向 National Centre for PTSD 索取有關訓練的資料及 CAPS 的手冊

Criterion A. The person has been exposed to a traumatic event in which both of the following were present:

1. the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
2. The person's response involved intense fear, helplessness, or horror. Note: in children, this may be expressed instead by disorganized or agitated behaviour.

我將會問你關於一啲難以處理或令人感到好大壓力的事，佢哋有時都會發生在不同人身上。其中一啲例子係身處某種嚴重嘅意外；身處火災，颶風（大風暴），或地震之中；被人襲擊，毆打，或者用武器襲擊；又或者在你不自願的情況之下強迫你發生性行為。

我會先請你從一系列類似呢啲經驗嘅例子，睇吓有無一啲係適用於你身上嘅。如果有嘅話，我就會再請你簡單敘述一下發生咗咩事同埋你當時嘅感受。

其中有啲經歷可能係想起會令你好難堪，或者會勾起一啲唔舒服嘅回憶同感覺，通常其他人會發覺講吓呢啲經歷係有幫助嘅。但係係你決定你想講幾多俾我聽。一路傾嘅時候，如果你發覺自己越嚟越辛苦，請你話俾我知，我哋可以放慢啲，同講吓啲唔舒服嘅感受。如果你有乜嘢問題，或者你有嘢唔明白，都請你話我知。

開始之前，你有冇乜嘢問題？

施行人生經歷檢核表

然後檢視並詢問其中最多三項事件。如果有超過三項事件被選出便要決定詢問那三項事件（例如：第一項，最糟及最近的事件；或三項最糟的事件；或想知更多的創傷事件加上兩項其他最糟的事件等）

如果沒有選擇檢核表中的任何事件：
（你有冇曾經試過生命有危險嘅情況，或者嚴重受傷或者被傷害？）

如果沒有：
(咁有冇曾經試過生命受威脅,或者被人威脅要傷害你呢?就算你冇真係受傷。)

如果沒有：
（咁你有冇試過目擊一啲類似嘅事發生喺其他人身上，或者發現呢啲事發生喺好親嘅人身上呢？）

如果沒有：
（咁如果要你講一啲曾經喺你生命中發生，令你感到有好大壓力嘅遭遇，你會點講呢？）

註：粗線字體代表標準的提問；斜字體代表跟進的提問。

EVENT # 1

發生咗咩事呢？*（你當時幾多歲？仲牽涉邊啲人？發生咗幾多次？生命受威脅？嚴重受傷？）*	形容（例如：事件的種類，受害者，侵犯者，年齡，發生頻率）：
咁你情緒上有咩反應？*（當時你有冇覺得好緊張或者好驚？嚇親？無助？係點呢？當時你嚇呆咗或者太驚所以完全冇乜感覺？係似點喫？其他人留意到你嘅情緒反應係點呢？咁件事發生之後，你又有乜嘢情緒反應？）*	**A. (1)** 生命威脅？ 沒有 有 （自己_____其他人_____） 嚴重損害？ 沒有 有 （自己_____其他人_____） 對身體完整性有威脅？ 沒有 有 （自己_____其他人_____） **A. (2)** 強烈的驚恐／無助/恐怖感受？ 沒有 有 （當時_____之後_____） 符合準則 A？ 否 可能 是

EVENT # 2

發生咗咩事呢？*（你當時幾多歲？仲牽涉邊啲人？發生咗幾多次？生命受威脅？嚴重受傷？）*	形容（例如: 事件的種類，受害者，侵犯者，年齡，發生頻率）：
咁你情緒上有咩反應？*（當時你有冇覺得好緊張或者好驚？嚇親？無助？係點呢？當時你嚇呆咗或者太驚所以完全冇乜感覺？係似點喫？其他人留意到你嘅情緒反應係點呢？咁件事發生之後，你又有乜嘢情緒反應？）*	**A. (1)** 生命威脅？ 沒有 有 （自己_____其他人_____） 嚴重損害？ 沒有 有 （自己_____其他人_____） 對身體完整性有威脅？ 沒有 有 （自己_____其他人_____） **A. (2)** 強烈的驚恐／無助／恐怖感受？ 沒有 有 （當時_____之後_____） 符合準則 A？ 否 可能 是

EVENT # 3

發生咗咩事呢？*（你當時幾多歲？仲牽涉邊啲人？發生咗幾多次？生命受威脅？嚴重受傷？）*	形容（例如：事件的種類，受害者，侵犯者，年齡，發生頻率）：
咁你情緒上有咩反應？*（當時你有冇覺得好緊張或者好驚？嚇親？無助？係點呢？當時你嚇呆咗或者太驚所以完全冇乜感覺？係似點喫？其他人留意到你嘅情緒反應係點呢？咁件事發生之後，你又有乜嘢情緒反應？）*	**A. (1)** 生命威脅？ 沒有 有 （自己_____其他人_____） 嚴重損害？ 沒有 有 （自己_____其他人_____） 對身體完整性有威脅？ 沒有 有 （自己_____其他人_____） **A. (2)** 強烈的驚恐/無助/恐怖感受？ 沒有 有 （當時_____之後_____） 符合準則 A？ 否 可能 是

喺跟住落嚟嘅訪問，我想你諗住頭先講過嘅（事情），嚟答一啲關於佢點樣影響你嘅問題。

我將會問你總共大約25題問題，大部份問題分成兩部份。首先，我會問你有冇試過有某一種特殊情況，如果有，喺過去一個月（星期）發生咗幾多次，然後，我會問你嗰個情況令你有幾不安或者唔舒服。

Criterion B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

1. **(B-1)** recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

頻率 **你有冇曾經試過有啲唔想有嘅，關於（事情）嘅回憶？佢哋係點嚟？***（你記得啲乜嘢？）*[如果不清楚：]*（佢哋試過曾經喺你醒嘅時候定係只喺你夢中出現？）*[排除只在夢裏出現的回憶] **喺過去一個月（星期）你有幾多次有呢啲回憶？** 0　從不 1　一次或兩次 2　一星期一次或兩次 3　一星期數次 4　每天或差不多每天 ***形容／例子***	***強度*** **呢啲回憶令你有幾不安或唔舒服？** **你可唔可以唔諗佢，諗第二啲嘢？***（試過有幾難？）***佢哋有幾干擾你嘅日常生活？** 0　沒有 1　輕微，極微的不安或影響活動 2　中度，有顯著的不安但依然可處理，對活動有些影響 3　嚴重，相當不安，回憶難以揮去，對活動有顯著的影響 4　極度，使人失去能力的不安，回憶不能揮去，不能繼續活動 ***QV（註明）*** ____________________	***過去一星期*** *F* ____ *I* ____ ***過去一個月*** *F* ____ *I* ____ *Sx:* *有 沒有* ***終身*** *F* ____ *I* ____ *Sx:* *有 沒有*

2. **(B-2)** recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

頻率 **你有冇試過有啲關於（事情）唔舒服嘅夢？請你形容其中一個成日發嘅夢***（夢入面發生咩事？）***喺過去一個月（星期），你有幾多次發呢啲夢?** 0 從不 1 一次或兩次 2 一星期一次或兩次 3 一星期數次 4 每天或差不多每天 ***形容／例子***	***強度*** **呢啲夢令你有幾不安或者唔舒服？** **有冇試過令你扎醒？**[如果有：]*（你醒咗之後會點呢？你要幾耐先可以瞓番？）*[留意有關緊張警醒，叫喊，把惡夢宣洩出來的報告] *（你啲夢有冇影響其他人？點樣影響呀？）* 0 沒有 1 輕微，極微的不安，可能不會醒過來 2 中度，在不安中醒過來但沒有困難再入睡 3 嚴重，相當不安，有困難再入睡 4 極度，使人失去能力的不安，不會再入睡 ***QV（註明）*** ____________________	***過去一星期*** *F* ____ *I* ____ ***過去一個月*** *F* ____ *I* ____ *Sx: 有 沒有* ***終身*** *F* ____ *I* ____ *Sx: 有 沒有*

3. **(B-3)** acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, traumatic specific re-enactment may occur.

頻率 **你有無試過突然間你做咗啲行為或者有啲感覺好似（事情）又再發生咁？**（*有冇試過有啲（事情）嘅片段閃過？*）[如果不清楚：] *喺你醒嘅時候，定淨係喺夢入面發生？* [排除只在夢裏出現的回憶] **講多啲有關呢啲片段（經歷）嘅嘢俾我聽。過去一個月（星期）發生過幾多次呢啲情形?** 0 從不 1 一次或兩次 2 一星期一次或兩次 3 一星期數次 4 每天或差不多每天 ***形容／例子***	***強度*** **嗰啲情況有幾似（事情）好似又再發生咁？**（*你有冇覺得混亂，唔知你當時真正喺邊，做緊乜嘢？*）**持續咗幾耐？當呢個情況發生時，你做緊咩嘢？**（*其他人有冇留意到你嘅行為，佢哋點講？*） 0 沒有再體驗 1 輕微，比只想起事件像較為真實 2 中度，肯定有但短暫的抽離質素，依然對週圍環境有高度醒覺，發白日夢的質素 3 嚴重，強烈的抽離（說有影象，聲音或嗅到味道）但保留對週圍環境的一些醒覺 4 極度，完全抽離（經驗回閃)，對週圍環境失去醒覺，可能沒有反應，對此事件段落可能失憶（眼前昏黑） ***QV（註明）*** ____________	***過去一星期*** *F* ____ *I* ____ ***過去一個月*** *F* ____ *I* ____ *Sx: 有 沒有* ***終身*** *F* ____ *I* ____ *Sx: 有 沒有*

4. **(B-4)** intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

頻率	*強度*	*過去一星期*
你有冇試過當有一啲嘢令你諗起（事情），你變得情緒不安？ *（有冇乜嘢引起一啲同（事情）有關唔好嘅感受？）* **有啲乜嘢會令你諗番起件事同覺得不安嘅？喺過去一個月（星期）發生過幾多次？** 0　從不 1　一次或兩次 2　一星期一次或兩次 3　一星期數次 4　每天或差不多每天 *形容／例子*	**嗰啲提醒番你有關（事情）嘅（人、事或者物件），令你有幾不安或者唔舒服？ 嗰啲感覺維持幾耐？佢哋有幾影響你嘅生活？** 0　沒有 1　輕微，極微的不安或影響活動 2　中度，有顯著的不安，但依然可處理，對活動有些影響 3　嚴重，相當不安，對活動有顯著的影響 4　極度，使人失去能力的不安，不能繼續活動 *QV（註明）* ____________________	*F* ____ *I* ____ *過去一個月* *F* ____ *I* ____ *Sx: 有 沒有* *終身* *F* ____ *I* ____ *Sx: 有 沒有*

5. **(B-5)** physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

頻率	***強度***	***過去一星期***
你有冇試過，當有一啲嘢令你諗起（事情）身體就出現一啲反應？*（有冇試過當有一啲嘢令你諗起（事情），你身體有某啲特別嘅反應？）***可唔可以俾啲例子我？***（你有冇心跳加速，呼吸有改變？係咁出汗，覺得個人拉緊咗或者震呢？）***有啲乜嘢提醒番件（事情）會令你有呢啲反應？喺過去一個月（星期）發生過幾多次？** 0 從不 1 一次或兩次 2 一星期一次或兩次 3 一星期數次 4 每天或差不多每天 ***形容／例子***	**（身體反應）有幾強烈/犀利）？佢哋持續幾耐？***（會唔會就算你離開咗個情況／環境，啲反應仍然持續？）* 0 沒有身體反應 1 輕微，極微的反應 2 中度，身體反應清楚存在，如果暴露延續，這些反應或會持續 3 嚴重，顯著的身體反應，於暴露時持續 4 極度，戲劇性的身體反應，驚覺狀態在暴露完結後持續 ***QV（註明）*** ____________________	*F* ____ *I* ____ ***過去一個月*** *F* ____ *I* ____ *Sx: 有 沒有* ***終身*** *F* ____ *I* ____ *Sx: 有 沒有*

Criterion C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

6. **(C-1)** efforts to avoid thoughts, feelings, or conversations associated with the trauma

頻率 ***Frequency*** **你有冇過嘗試逃避一啲有關（事情）嘅思想或者感覺？** *（係啲乜嘢嘅思想或者感覺你嘗試避免？）* **咁逃避同人講（事情）呢？** *（點解呢？）* **喺過去一個月（星期）發生過幾多次？** 0 從不 1 一次或兩次 2 一星期一次或兩次 3 一星期數次 4 每天或差不多每天 ***形容／例子***	***強度*** ***Intensity*** **你要有幾努力嚟逃避呢啲（思想／感覺／對話）？** *（你做咗啲乜嘢?咁飲酒或者藥物或者喺街買到嘅藥呢？）* [要考慮所有逃避的試圖，包括分散注意，抑壓，及利用酒精／藥物] **佢哋對你日常生活嘅干擾有幾大？** 0 沒有 1 輕微，極微的努力，對活動沒有或有些少影響 2 中度，頗努力，逃避肯定存在，對活動有些影響 3 嚴重，相當努力，顯著的逃避，對活動有顯著的影響，或以參予某些活動作為逃避的策略 4 極度，激烈的逃避試圖，不能繼續活動，或過份地參予某些活動作為逃避的策略 ***QV（註明）*** ____________________	***過去一星期*** *F* ____ *I* ____ ***過去一個月*** *F* ____ *I* ____ *Sx:* *有 沒有* ***終身*** *F* ____ *I* ____ *Sx:* *有 沒有*

7. **(C-2)** efforts to avoid activities, places, or people that arouse recollections of the trauma

<u>頻率</u>	***<u>強度</u>***	***<u>過去一星期</u>***
你有冇試過嘗試避免某啲會令你諗番（事情）嘅活動，地方或者人物呢？*（你避免邊樣嘢呢？點解？）***喺過去一個月（星期）發生過幾多次？** 0 從不 1 一次或兩次 2 一星期一次或兩次 3 一星期數次 4 每天或差不多每天 ***<u>形容／例子</u>***	**你要有幾努力嚟避免呢啲（活動／地方／人物）***（你實際做咗啲乜嘢？）***咁對你日常生活有幾大嘅干擾？** 0 沒有 1 輕微，極微的努力，對活動沒有或有些少影響 2 中度，頗努力，逃避肯定存在，對活動有些影響 3 嚴重，相當努力，顯著的逃避，對活動有顯著的影響，或以參予某些活動作為逃避的策略 4 極度，激烈的逃避試圖，不能繼續活動，或過份地參予某些活動作為逃避的策略 ***<u>QV（註明）</u>*** ____________________	*F* ____ *I* ____ ***<u>過去一個月</u>*** *F* ____ *I* ____ *Sx: 有 沒有* ***<u>終身</u>*** *F* ____ *I* ____ *Sx: 有 沒有*

8. **(C-3)** inability to recall an important aspect of the trauma

頻率 **你有冇試過有困難去記起（事情）一啲重要嘅環節？講多啲俾我聽。***（你有冇覺得你應該可以記得佢哋呢？咁你覺得點解你唔得?）* **喺過去一個月（星期），有幾多關於（事情）嘅重要環節，你有困難去記起？***（仲有邊啲部份你係記得嘅呢？）* 0 沒有，能清楚記起 1 不能記起數個環節（少於10%） 2 不能記起好幾個環節（約20–30%） 3 不能記起好多個環節（約50–60%） 4 不能記起大部份環節（多於80%） ***形容／例子***	***強度*** **你有幾大困難要去記番（事情）嘅重要環節？***（如果你試吓，會唔會記得番多啲？）* 0 沒有 1 輕微，極微的困難 2 中度，頗困難，用努力便可記起 3 嚴重，就算努力亦相當困難 4 極度，完全不能記起事件的重要環節 ***QV（註明）*** ____________________	***過去一星期*** *F* ____ *I* ____ ***過去一個月*** *F* ____ *I* ____ *Sx:* *有 沒有* ***終身*** *F* ____ *I* ____ *Sx:* *有 沒有*

9. **(C-4)** markedly diminished interest or participation in significant activities

頻率	***強度***	***過去一星期***
你有冇對一啲你曾經享受/鐘意嘅活動少咗興趣？*（你對啲乜嘢少咗興趣？有冇一啲嘢你完全冇再做？點解呢？）*[排除因沒有機會，身體能力不及，或合適成長而改變了的喜好活動] **喺過去一個月（星期），你對幾多活動少咗興趣？***（有啲乜嘢你仲有興趣做？）* **幾時開始你覺得咁樣？***（[事情] 之後？）* 0 沒有 1 數項活動（少於10%） 2 好幾項活動（約20–30%） 3 多項活動（50–60%） 4 大部份或所有活動（多於80%） ***形容／例子***	**你失去興趣嘅情況有幾嚴重？***（會唔會當你開始番，會鍾意番[活動]？）* 0 沒有失去興趣 1 輕微，些少失去興趣，活動開始後可能會享受 2 中度，肯定失去興趣，但依然頗享受活動 3 嚴重，顯著地對活動失去興趣 4 極度，完全失去興趣，不再參與任何活動 ***QV（註明）*** ____________________ ***與創傷有關？*** *1 肯定　2 可能　3 不大可能* *現時* ______　*終身* ______	*F* ____ *I* ____ ***過去一個月*** *F* ____ *I* ____ *Sx: 有 沒有* ***終身*** *F* ____ *I* ____ *Sx: 有 沒有*

10. **(C-5)** feeling of detachment or estrangement from others

頻率	*強度*	*過去一星期*
你有冇覺得同人疏遠咗或者斷絕咗聯繫？啲感覺係點㗎？喺過去一個月（星期）有幾多時間你覺得係咁？你幾時第一次開始覺得咁樣？*（[事情] 之後？）*	**呢啲同人疏遠咗或者斷絕咗聯繫嘅感覺有幾強烈呀？**（*你覺得邊個同你好親近？有幾多人你會覺得舒服同佢講自己嘅嘢？*）	*F* ____ *I* ____
0 沒有時候 1 很少時候（少於10%） 2 有些時候（20–30%） 3 相當多時候（50–60%） 4 大部份或所有時候（多於80%）	0 沒有疏遠或斷絕聯繫的感覺 1 輕微，可能感到與其他人「唔夾」 2 中度，疏遠的感覺清楚存在，但依然感到有人際的聯繫 3 嚴重，顯著疏遠的感覺或與大部份人斷絕聯繫，可能只與一至兩個人感到親密 4 極度，感到與其他人完全疏遠或斷絕聯繫，與任何人也不感到親密	*過去一個月* *F* ____ *I* ____ *Sx:* *有 沒有*
形容／例子	*QV（註明）* ____________________ *與創傷有關？* *1 肯定　2 可能　3 不大可能* *現時* ______　*終身* ______	*終身* *F* ____ *I* ____ *Sx:* *有 沒有*

11. **(C-6)** restricted range of affect (e.g., unable to have loving feelings)

頻率 **你有冇試過有啲時候你覺得麻木或者有困難去感受一啲情感，好似愛或者愉快嘅情感？係點喫？** *（乜嘢感覺你有困難去感受？）* **喺過去一個月（星期），有幾多時候你覺得係咁？你幾時第一次開始有困難去感受（情感）** *（[事情] 之後？）* 0 沒有時候 1 很少時候（少於10%） 2 有些時候（20–30%） 3 相當多時候（50–60%） 4 大部份或所有時候（多於80%） ***形容／例子***	***強度*** **有幾大困難去感受（情感）？** *（有乜嘢感覺你仍然可以感受到？）*[包括在會談中對各種情緒的觀察] 0 沒有失去情感的感覺 1 輕微，些少失去情感的感覺 2 中度，肯定失去情感的感覺，但依然能感覺到大部份的情感 3 嚴重，顯著地失去最少兩種主要情感的感覺（例如：愛、快樂） 4 極度，完全失去情感的感覺 ***QV（註明）*** ____________________ ***與創傷有關？*** *1 肯定　2 可能　3 不大可能* *現時 ______　終身 ______*	***過去一星期*** *F ____* *I ____* ***過去一個月*** *F ____* *I ____* *Sx: 有 沒有* ***終身*** *F ____* *I ____* *Sx: 有 沒有*

12. **(C-7)** sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

頻率 **有冇試過有時候你覺得無須為將來計劃／打算，就莫名其妙咁你嘅將來會縮短／短暫咗？點解呢？**[排除與現實相乎的危險，例如威脅生命的醫療狀況] **喺過去一個月（星期），有幾多時候你覺得係咁？** **你幾時第一次開始覺得咁樣？** *（[事情]之後？）* 0 沒有時候 1 很少時候（少於10%） 2 有些時候（20–30%） 3 相當多時候（50–60%） 4 大部份或所有時候（多於80%） ***形容／例子***	***強度*** **你感到將來縮短咗嘅感覺有幾強烈？** *（你覺得你會生存多幾耐？你有幾相信你會過早死亡？）* 0 沒有前途無望的感覺 1 輕微，些少前途無望的感覺 2 中度，前途無望的感覺肯定存在，但對壽命沒有具體的預測 3 嚴重，前途無望的感覺顯著，可能會對壽命有具體的預測 4 極度，前途無望的感覺勢不可擋，對過早的死亡完全認同 ***QV（註明）*** ____________________ ***與創傷有關？*** *1 肯定　2 可能　3 不大可能* *現時* ______　*終身* ______	***過去一星期*** *F* ____ *I* ____ ***過去一個月*** *F* ____ *I* ____ *Sx：有 沒有* ***終身*** *F* ____ *I* ____ *Sx：有 沒有*

Criterion D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

13. **(D-1)** difficulty falling or staying asleep

頻率 **你有冇試過有困難入睡或者保持喺睡眠狀態？喺過去一個月（星期）發生過幾多次？** **你幾時第一次開始有困難瞓覺？** *（[事情] 之後？）* 0　從不 1　一次或兩次 2　一星期一次或兩次 3　一星期數次 4　每天或差不多每天 入睡問題？　有　沒有 睡眠中途醒來？　有　沒有 零晨時份醒來？　有　沒有 每晚睡眠的總共時數 _____ 每晚睡眠的要求時數 _____	***強度*** **你瞓覺方面有幾大困難？***（你要幾耐先瞓得著？半夜扎醒有幾密？有冇經常比你想嘅早醒咗？每晚你總共瞓幾多個鐘？）* 0　沒有睡眠問題 1　輕微，須要入睡的時間長了少許，或有極微的困難保持入睡（失眠不超過30分鐘） 2　中度，肯定有睡眠困擾，須要入睡的時間清楚地長了，或有清楚的困難保持入睡（失眠30–90分鐘） 3　嚴重，須要入睡的時間長了很多，或有顯著的困難保持入睡（90分鐘至3小時的睡眠） 4　極度，須要入睡的時間很長，或有嚴重的困難保持入睡（失眠超過3小時） ***QV（註明）*** ____________________ ***與創傷有關？*** *1 肯定　2 可能　3 不大可能* *現時 ______　終身 ______*	***過去一星期*** *F* ____ *I* ____ ***過去一個月*** *F* ____ *I* ____ *Sx: 有 沒有* ***終身*** *F* ____ *I* ____ *Sx: 有 沒有*

14. **(D-2)** irritability or outbursts of anger

頻率 **有冇試過有時候你覺得特別忟憎／煩躁或者發嬲發得好犀利？可唔可以俾啲例子我？喺過去一個月（星期）發生過幾多次？你幾時第一次開始覺得咁樣？***（[事情]之後？）* 0 從不 1 一次或兩次 2 一星期一次或兩次 3 一星期數次 4 每天或差不多每天 ***形容／例子***	***強度*** **你發嬲有幾強烈？***（你點樣表現出嚟？）* [如果報告有抑壓：] *（你有幾難去忍住唔將啲嬲怒發洩出嚟？）* **你要用幾耐至冷靜番？你呢啲嬲怒嘅情緒有冇對你造成任何問題？** 0 沒有煩躁或忿怒 1 輕微，極微的煩躁，忿怒時或會提高嗓子 2 中度，肯定煩躁或試圖抑壓忿怒，但能很快復原 3 嚴重，顯著煩躁或顯著地試圖抑壓忿怒，忿怒時可能會在語言或身體上變得暴力 4 極度，忿怒彌漫或抑壓忿怒的激烈試圖，可能會出現身體暴力的情節 ***QV（註明）*** ____________________ ***與創傷有關？*** *1 肯定　2 可能　3 不大可能* *現時* ______　*終身* ______	***過去一星期*** *F* ____ *I* ____ ***過去一個月*** *F* ____ *I* ____ *Sx: 有 沒有* ***終身*** *F* ____ *I* ____ *Sx: 有 沒有*

15. **(D-3)** difficulty concentrating

頻率 **你有冇發覺有困難去集中於你做緊嘅事或者喺你周圍發生緊嘅嘢？喺點㗎？喺過去一個月（星期）有幾多時候係咁呀？你幾時第一次開始有困難集中精神？***（[事情] 之後？）* 0 沒有時候 1 很少時候（少於10%） 2 有些時候（20–30%） 3 相當多時候（50–60%） 4 大部份或所有時候（多於80%） ***形容／例子***	***強度*** **你有幾難去集中精神？**[包括在會談中對集中力及注意力的觀察]**佢對你日常生活嘅干擾有幾大？** 0 集中力沒有困難 1 輕微，集中時只須少許的努力，對活動沒有或有少許影響 2 中度，肯定失去集中力，但若努力便可集中，對活動有顯著的影響 3 嚴重，就算努力也顯著地失去集中力，對活動有顯著的影響 4 極度，完全不能集中，不能參與活動 ***QV（註明）*** ____________________ ***與創傷有關？*** *1 肯定　2 可能　3 不大可能* *現時 ______　終身 ______*	***過去一星期*** *F* ____ *I* ____ ***過去一個月*** *F* ____ *I* ____ *Sx: 有 沒有* ***終身*** *F* ____ *I* ____ *Sx: 有 沒有*

16. **(D-4)** hypervigilance

頻率 **你有冇試過就算冇咁嘅實際需要都特別警剔或特別留心？***（你有冇覺得你好似無時無刻都要提高警覺）***點解呢？喺過去一個月（星期）有幾多時候係咁呀？你幾時第一次開始要咁樣做？***（[事情] 之後？）* 0 沒有時候 1 很少時候（少於10%） 2 有些時候（20–30%） 3 相當多時候（50–60%） 4 大部份或所有時候（多於80%） ***形容／例子***	***強度*** **你有幾努力令自己無時無刻都提高警剔？**[包括在面談中觀察到的過份警覺] **你呢啲（過度警剔）有冇對你造成問題？** 0 沒有過份警覺 1 輕微，極微的過份警覺，注意提高了少許 2 中度，過份警覺清楚存在，在公眾地方有所警剔（例如在餐館或戲院選擇安全的位置來坐） 3 嚴重，顯著地過份警覺，非常留神，審視環境是否危險，誇張地關心自己／家人／家居的安全 4 極度，過度的過份警覺，為確保安全用去很多時間及氣力及可能包括廣泛的檢查和確保安全的行為，在面談時有顯著的戒備 ***QV（註明）*** ____________________ ***與創傷有關？*** *1 肯定　2 可能　3 不大可能* *現時* ______ *終身* ______	***過去一星期*** *F* ____ *I* ____ ***過去一個月*** *F* ____ *I* ____ *Sx: 有 沒有* ***終身*** *F* ____ *I* ____ *Sx: 有 沒有*

17. **(D-5)** exaggerated startle response

頻率	***強度***	***過去一星期***
你有冇試過有任何強烈受驚嚇嘅反應？ **幾時發生過呢啲情況呢？** *（係邊啲嘢／乜嘢令你咁驚？）* **喺過去一個月（星期）發生過幾多次？** **你幾時開始第一次有咁嘅反應？** *（[事情] 之後？）* 0　從不 1　一次或兩次 2　一星期一次或兩次 3　一星期數次 4　每天或差不多每天 ***形容／例子***	**呢啲驚嚇嘅反應有幾強烈？** *（同大部份的人反應比較，佢哋有幾強烈？）* **佢哋會維持幾耐？** 0　沒有驚嚇的反應 1　輕微，極微的反應 2　中度，肯定有驚嚇反應，感到提心吊膽 3　嚴重，顯著的驚嚇反應，最初反應過後激發依然會持續 4　極度，過份驚嚇反應，公然地作出因應的行為（例如：戰鬥退役軍人伏在地上以作掩護） ***QV（註明）*** ____________________ ***與創傷有關？*** *1 肯定　2 可能　3 不大可能* *現時* ______　*終身* ______	*F* ____ *I* ____ ***過去一個月*** *F* ____ *I* ____ *Sx: 有 沒有* ***終身*** *F* ____ *I* ____ *Sx: 有 沒有*

Criterion E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

18. 症狀的開始

[如還未清楚：]**你幾時開始第一次有呢啲頭先同我講嘅創傷後壓力癥狀）？***（[事情]之後幾耐開始？多過六個月？）*	***延遲了共#月___________才開始*** ***延遲開始（≥六個月）？　否　是***

19. Duration of symptoms

[現時] **一路以來呢啲（創傷後壓力癥狀）總共維持咗幾耐？**	*持續超過一個月？* *持續共#月* *急性（<三個月）或* *慢性（≥三個月）？*	***現時*** ***否　是*** ________ ***急性　慢性***	***終身*** ***否　是*** ________ ***急性　慢性***
[終身] **過去呢啲（創傷後壓力癥狀）總共維持咗幾耐？**			

Criterion F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

20. Subjective distress

[現時] **總括嚟講，你頭先同我講嗰啲（創傷後壓力癥狀）一路以來對你有幾困擾？** [考慮在之前項目已報告的不安] **[終身]** **總括嚟講，你頭先同我講嗰啲（創傷後壓力癥狀）過去對你有幾困擾？** [考慮在之前項目已報告的不安]	0 沒有 1 輕微，極微的不安 2 中度，有顯著的不安但依然可處理 3 嚴重，相當不安 4 極度，使人失去能力的不安	***過去一星期*** ______ ***過去一個月*** ______ ***終身*** ______

21. Impairment in social functioning

[現時] **一路以來呢啲（創傷後壓力癥狀）有無影響你同其他人嘅關係？喺點樣？** [考慮在之前項目已報告有關社交功能上的損傷] **[終身]** **過去呢啲（創傷後壓力癥狀）有無影響你同其他人嘅關係？喺點樣？** [考慮在之前項目已報告有關社交功能上的損傷]	0 沒有不良的影響 1 輕微，在社交功能上有極微的損傷 2 中度影響，肯定有損傷，但多方面的社交功能依然完整無缺 3 嚴重影響，顯著的損傷，有些社交功能依然完整無缺 4 極度影響，沒有或只有少許社交功能	***過去一星期*** ______ ***過去一個月*** ______ ***終身*** ______

22. Impairment in occupational or other important area of functioning

[現時——如還未清楚] 你而家有冇做緊嘢？ 如果有：**一路以來呢啲（創傷後壓力癥狀）有冇影響你嘅工作或者工作能力？喺點樣影響？**[考慮已報告的工作履歷，包括工作的數量及持續時間，以及與同事關係的質素。若不清楚病發前的功能，便詢問有關創傷前的工作經驗。對於兒童／青少年的創傷，要評估創傷前在學校的表現及可能存在的行為問題] 如果沒有：**一路以來呢啲（創傷後壓力癥狀）有冇影響任何其他你生活中重要嘅部份呢？**[如適合，可提議例子如管教仔女，做家務，做學校嘅工作，義工服務等] **點樣影響？** **[終身——如還未清楚] 當時你有冇做緊嘢？** 如果有：**過去呢啲（創傷後壓力癥狀）有冇影響你嘅工作或者工作能力？點樣影響？**[考慮已報告的工作履歷，包括工作的數量及持續時間，以及與同事關係的質素。若不清楚病發前的功能，便詢問有關創傷前的工作經驗。對於兒童／青少年的創傷，要評估創傷前在學校的表現及可能存在的行為問題] 如果沒有：**過去呢啲（創傷後壓力癥狀）有冇影響任何其他你生活中重要嘅部份呢？**[如適合，可提議例子如管教仔女，做家務，做學校嘅工作，義工服務等] **點樣影響？**	0 沒有不良的影響 1 輕微，在職業功能上有極微的損傷 2 中度影響，肯定有損傷，但多方面的職業功能依然完整無缺 3 嚴重影響，顯著的損傷，有些職業功能依然完整無缺 4 極度影響，沒有或只有少許職業功能	***過去一星期*** ______ ***過去一個月*** ______ ***終身*** ______

Global ratings

23. 總體有效性

估計總體的有效性或反應。 考慮因素包括在面談時的依從性，精神狀態（例如：集中的困難，對項目的理解，抽離），努力地誇大或低估症狀的証據。	0 非常好，沒有理由去懷疑答案是無效的
	1 好，存在可能對有效性有不良影響的因素
	2 尚可，存在肯定會減低有效性的因素
	3 劣，有效性大大地減低
	4 無效的答案，精神狀態嚴重地損傷或可能刻意去“假裝壞”或“假裝好”

24. 總體嚴重性

估計創傷後壓力症症狀的總體嚴重性。考慮主觀不安的程度，功能損傷的程度，在面談中觀察到的行為及對表達風格的判斷。	0 沒有顯著的臨床症狀，沒有不安及沒有功能上的損傷	***過去一星期*** ________
	1 輕微，極微的不安或功能上的損傷	
	2 中度，確切的不安或功能上的損傷，但若努力便有滿意的操作	***過去一個月*** ________
	3 嚴重，相當不安或功能上的損傷，就算努力，功能都是有限	
	4 極度，顯著的不安或在兩或更多項的主要功能範圍上有顯著的損傷	***終身*** ________

25. 總體的改進

評價由最初評估時開始總共的整體改進。如果沒有先前的評估，則詢問已記錄的症狀在過去六個月如何改變過來。評價改變的程度，在你的判斷中是否因治療而做成。	0 無症狀的
	1 相當的改進
	2 中度的改進
	3 少許的改進
	4 沒有改進
	5 資料不足

Current PTSD symptoms

可滿足條件A（創傷事件）？ 否 是

_______*#條件B sx（>1）？* 否 是

_______*#條件C sx（>3）？* 否 是

_______*#條件D sx（>2）？* 否 是

可滿足條件E（持續>一個月）？ 否 是

可滿足條件F（不安／損傷）？ 否 是

現時創傷後壓力症（可滿足條件A–F）？ 否 是

如果未能滿足現時患創傷後壓力症的條件，便跳往伴隨之特質。

如果未能滿足現時患創傷後壓力症的條件，則作終身創傷後壓力症的評估。識別在創傷事件以來一段最少有一個月症狀最差劣的日子。

（事情）之後，有冇試過有一段時間呢啲（創傷後壓力癥狀）比過去一個月再差好多？嗰時係幾時？維持咗幾耐？ *（最少一個月？）*

如果過去有多段日子：**曾經喺幾時最被呢啲（創傷後壓力癥狀）困擾？**

如果最少有一段日子，則查詢第1–17項，並將有關頻密程度的提問改為在最惡劣的日子中的情況：
喺嗰段時間，你有冇（感到癥狀）？發生過幾多次？

Lifetime PTSD symptoms

可滿足條件A（創傷事件）？ 否 是

_______#條件B sx（>1）？ 否 是

_______#條件C sx（>3）？ 否 是

_______#條件D sx（>2）？ 否 是

可滿足條件E（持續>一個月）？ 否 是

可滿足條件F（不安／損傷）？ 否 是

終身創傷後壓力症（可滿足條件A–F）？ 否 是

Associated Features

26. Guilt over acts of commission or omission

頻率 **你有冇對（事情）當時你做咗或者冇做任何嘅嘢感到內疚？講多啲俾我聽** *（你對乜嘢感到內疚？）* **喺過去一個月（星期）有幾多時候覺得咁？** 0 沒有時候 1 很少時候（少於10%） 2 有些時候（20–30%） 3 相當多時候（50–60%） 4 大部份或所有時候（多於80%） ***形容／例子***	***強度*** **呢啲內疚嘅感覺有幾強烈？佢哋令你有幾不安或唔舒服？** 0 沒有內疚感 1 輕微，少許內疚感 2 中度，內疚感肯定存在，有些不安但依然可應付 3 嚴重，顯著內疚的感覺，相當不安 4 極度，內疚感彌漫，自我譴責有關行為，使人失去能力的不安 ***QV（註明）*** ____________________	***過去一星期*** *F* ____ *I* ____ ***過去一個月*** *F* ____ *I* ____ *Sx:* *有* *沒有* ***終身*** *F* ____ *I* ____ *Sx:* *有* *沒有*

27. Surviving guilt（只應用於若有多個受害者）

頻率	***強度***	***過去一星期***
你有冇對你喺（事情）中倖存而其他人死去而感到罪疚？講多啲俾我聽。*（你對乜嘢感到罪疚？）***喺過去一個月（星期）有幾多時候覺得咁？** 0 沒有時候 1 很少時候（少於10%） 2 有些時候（20–30%） 3 相當多時候（50–60%） 4 大部份或所有時候（多於80%） ***形容／例子***	**呢啲罪疚嘅感覺有幾強烈？佢哋令你有幾不安或唔舒服？** 0 沒有內疚感 1 輕微，少許內疚感 2 中度，內疚感肯定存在，有些不安但依然可應付 3 嚴重，顯著內疚的感覺，相當不安 4 極度，內疚感彌漫，自我譴責有關倖存，使人失去能力的不安 ***QV（註明）*** ____________________	*F* ____ *I* ____ ***過去一個月*** *F* ____ *I* ____ *Sx：有 沒有* ***終身*** *F* ____ *I* ____ *Sx：有 沒有*

28. a reduction in awareness of his or her surroundings (e.g., “being in a daze”)

頻率	***強度***	***過去一星期***
你有冇試過有時候你對身邊發生嘅事失去接觸，或者個人好似迷迷茫咁？係點㗎？[與經驗回閃段落有所區分] **喺過去一個月（星期）發生過幾多次？**[如未清楚：] *（係咪因為病，或者係藥物或酒精嘅影響？）* **你幾時第一次開始覺得咁樣？** *（[事情]之後？）* 0 從不 1 一次或兩次 2 一星期一次或兩次 3 一星期數次 4 每天或差不多每天 ***形容／例子***	**呢啲失去接觸或者迷茫嘅感覺有幾強烈？** *（你有冇覺得混亂，唔知你當時真正喺邊或者做緊乜嘢？）* **持續咗幾耐？當呢個情況發生時，你做緊咩嘢？** *（其他人有冇留意到你嘅行為，佢哋點講？）* 0 醒覺性沒有減低 1 輕微，醒覺性少許減低 2 中度，醒覺性肯定有但只短暫減低 3 嚴重，醒覺性顯著減低，可能持續幾小時 4 極度，對周圍的醒覺性完全失去，可能有反應，對此事件段落可能失憶（眼前昏黑） ***QV（註明）*** ____________________ ***與創傷有關？*** *1 肯定　2 可能　3 不大可能* *現時* ______　*終身* ______	*F* ____ *I* ____ ***過去一個月*** *F* ____ *I* ____ *Sx: 有　沒有* ***終身*** *F* ____ *I* ____ *Sx: 有　沒有*

29. derealization

頻率 **你有冇試過有時候你身邊發生嘅嘢好似唔真實，或者好奇怪，好唔熟悉咁？**[如果沒有：]*（有冇時候你識嘅人突然好似陌生咁？）* **係點樣㗎？喺過去一個月（星期）發生過幾多次？**[如不清楚：] *係咪因為病或者係藥物或酒精嘅影響？）* **你幾時第一次開始覺得咁樣？** *（[事情] 之後？）* 0 從不 1 一次或兩次 2 一星期一次或兩次 3 一星期數次 4 每天或差不多每天 ***形容／例子***	***強度*** **呢啲（喪失現實感嘅感覺)有幾強烈？持續咗幾耐?當呢個情況發生時你做緊咩嘢？** *（其他人有冇留意到你嘅行為，佢哋點講？）* 0 沒有喪失現實感 1 輕微，少許喪失現實感 2 中度，肯定有但只短暫喪失現實感 3 嚴重，相當地喪失現實感，顯著地混淆有關什麼是現實，可能持續數小時 4 極度，嚴重地喪失現實感，戲劇性地失去現實的感覺或熟悉的感覺 ***QV（註明）*** ____________________ ***與創傷有關？*** *1 肯定 2 可能 3 不大可能* *現時* ______ *終身* ______	***過去一星期*** *F* ____ *I* ____ ***過去一個月*** *F* ____ *I* ____ *Sx: 有 沒有* ***終身*** *F* ____ *I* ____ *Sx: 有 沒有*

30. depersonalization

頻率 **你有冇試過有時候你覺得你離開咗你個身體，睇緊你自己就好似你係另一個人咁？**[如果沒有：] *（咁有冇時候你覺得個身體奇怪或者陌生？好似佢喺某方面唔同咗/改變咗？）* **係點樣㗎？喺過去一個月（星期）發生過幾多次？**[如不清楚：] *（係咪因為病，或者係藥物或酒精嘅影響？）* **你幾時第一次開始覺得咁樣？** *（ [事情] 之後？）* 0　從不 1　一次或兩次 2　一星期一次或兩次 3　一星期數次 4　每天或差不多每天 ***形容／例子***	***強度*** **呢啲 (喪失自我感嘅感覺)有幾強烈？持續咗幾耐？當呢個情況發生時你做緊咩嘢？** *（其他人有冇留意到你嘅行為，佢哋點講？）* 0　沒有喪失自我感 1　輕微，少許喪失自我感 2　中度，肯定有但短暫喪失自我感 3　嚴重，相當地喪失自我感，顯著有自我分離的感覺，可能持續數小時 4　極度，嚴重地喪失自我感，戲劇性地有自我分離的感覺 ***QV（註明）*** ____________________ ***與創傷有關？*** *1 肯定　　2 可能　　3 不大可能* *現時* ______　*終身* ______	***過去一星期*** *F* ____ *I* ____ ***過去一個月*** *F* ____ *I* ____ *Sx: 有 沒有* ***終身*** *F* ____ *I* ____ *Sx: 有 沒有*

Clinician-Administered PTSD Scale for DSM-IV (CAPS-DX). Reprinted with permission from National Center of Posttraumatic Stress Disorder (NCPTSD) 保留所有權利。中文版由 Wu, K. K., & Chu, L. Y. (2004) 翻譯。經美國 NCPTSD 許可翻譯複印。

CAPS SUMMARY SHEET

Name:______________________ ID#:_________ Interviewer:_____________

Study:______________________ Date:_________

A. Traumatic event:

B. Reexperiencing symptoms	*PAST WEEK*			*PAST MONTH*			*LIFETIME*		
	Freq	*Int*	*F+I*	*Freq*	*Int*	*F+I*	*Freq*	*Int*	*F+I*
(1) intrusive recollections									
(2) distressing dreams									
(3) acting or feeling as if event were recurring									
(4) psychological distress at exposure to cues									
(5) physiological reactivity on exposure to cues									
B subtotals									
Number of Criterion B symptoms (need 1)									

C. Avoidance and numbing symptoms	*PAST WEEK*			*PAST MONTH*			*LIFETIME*		
	Freq	*Int*	*F+I*	*Freq*	*Int*	*F+I*	*Freq*	*Int*	*F+I*
(6) avoidance of thoughts or feelings									
(7) avoidance of activities, places, or people									
(8) inability to recall important aspect of trauma									
(9) diminished interest in activities									
(10) detachment or estrangement									
(11) restricted range of affect									
(12) sense of a foreshortened future									
C subtotals									
Number of Criterion C symptoms (need 3)									

D. Hyperarousal symptoms	*PAST WEEK*			*PAST MONTH*			*LIFETIME*		
	Freq	*Int*	*F+I*	*Freq*	*Int*	*F+I*	*Freq*	*Int*	*F+I*
(13) difficulty falling or staying asleep									
(14) irritability or outbursts of anger									
(15) difficulty concentrating									
(16) hypervigilance									
(17) exaggerated startle response									
D subtotals									
Number of Criterion D symptoms (need 2)									

Total Freq, Int, and Severity (F+I)	*PAST WEEK*			*PAST MONTH*			*LIFETIME*		
	Freq	*Int*	*F+I*	*Freq*	*Int*	*F+I*	*Freq*	*Int*	*F+I*
Sum of subtotals (B+C+D)									

E. Duration of disturbance	*CURRENT*	*LIFETIME*
(19) duration of disturbance at least one month	*NO YES*	*NO YES*

F. Significant distress or impairment in functioning	*PAST WEEK*	*PAST MONTH*	*LIFETIME*
(20) subjective distress			
(21) impairment in social functioning			
(22) impairment in occupational functioning			
AT LEAST ONE ≥ 2?	*NO YES*	*NO YES*	*NO YES*

PTSD diagnosis	*CURRENT*	*LIFETIME*
PTSD PRESENT -- ALL CRITERIA (A-F) MET?	*NO YES*	*NO YES*
Specify: (18) with delayed onset (≥ 6 months delay)	*NO YES*	*NO YES*
(19) acute (< 3 months) or chronic (≥ 3 months)	*acute chronic*	*acute chronic*

Global ratings	*PAST WEEK*	*PAST MONTH*	*LIFETIME*
(23) global validity			■
(24) global severity			
(25) global improvement			

Associated features	*PAST WEEK*			*PAST MONTH*			*LIFETIME*		
	Freq	*Int*	*F+I*	*Freq*	*Int*	*F+I*	*Freq*	*Int*	*F+I*
(26) guilt over acts of commission or omission									
(27) survivor guilt									
(28) reduction in awareness of surroundings									
(29) derealization									
(30) depersonalization									

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Appendix E

Chinese Version of Dissociative Experiences Scale (DES)

DES

Eve Bernstein Carlson, Ph. D.　　Frank W. Putnam, M. D.

說明：
下面二十八條問題是關於你在日常生活中可能有的一些經歷。我們希望知道這些經歷有幾經常發生。重要的是，這些經歷並不是因酒精或藥物的影響而發生的。

回答時，請決定所形容的經歷有若干程度適用於你的情況，並圈出適當的數字以表示你有百分之幾的時間有這種經歷。

例子：

0%	10	20	30	40	50	60	70	80	90	100%
（從來不會）										（總是會）

日期：________________

姓名：________________　　年齡：________　性別：________

1. 一些人會有這種經驗：在駕車或乘車時（包括私家車、巴士或地下鐵等），突然意識到自己記不起整段或部份車程內所發生的事情。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

2. 一些人發現有時候他們在聽別人説話時會突然意識到自己沒有聽到對方所説的全部或部分內容。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

3. 有些人曾試過發現自己身處某地方，而不知道自己是怎樣到達那裏的。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

4. 有些人曾試過發現自己穿着某些衣服，而記不起自己曾經穿上那些衣服。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

5. 有些人曾試過發現自己有一些新的東西而記不起自己曾買過那些東西。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

6. 有些人曾遇上他們不認識的人走近他們，並且以別的名字稱呼他們，或那些人堅持曾和他們見過面。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

7. 有些人曾試過感覺像是站在自己身旁或看着自己在做一些事，他們看着自己時就好像正看着另外一個人一樣。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

8. 有些人曾試過有人跟他們説他們有時不認得自己的朋友或家人。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

9. 有些人會發現自己記不起在他們生命中一些重要的事件（例如婚禮或畢業典禮等）。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

10. 有些人曾試過被指摘説謊，卻不認為自己曾説過謊。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

11. 有些人曾試過照鏡時認不出自己。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

12. 有些人曾試過覺得他們身邊的人、事物、和世界都不是真實的。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

13. 有些人曾試過覺得他們的身體不是屬於自己的。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

14. 有些人曾試過很清楚地記起過去某事件，就好像再次經歷那事件一樣。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

15. 有些人曾試過不能確定他們所記得發生過的事到底是真的發生過，還是夢境而已。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

16. 有些人曾試過身處一個熟悉的地方，卻感到那個地方很陌生和不熟悉。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

17. 有些人在看電視或電影時會非常投入，以致毫不察覺身邊正發生的其他事情。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

18. 有些人發現自己非常投入幻想或白日夢之中，猶如那些事情真的發生在自己身上。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

19. 有些人發現有時候他們能夠不理會痛楚。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

20. 有些人發現有時候他們會呆坐一處，腦海一片空白，而且沒有察覺時間流逝。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

21. 有些人有時會發現當他們獨自一人時，會對自己大聲説話。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

22. 有些人發現自己在某種情況下的行為表現與在另一個情況下非常不同，以致他們感到自己好像是兩個不同的人。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

23. 有些人發現一些通常對於他們來説很困難的事情，在某情況下居然能夠輕易自如地做得到（例如：運動、工作、社交等等）。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

24. 有些人有時發現他們記不起自己是否曾經做過某件事，還是只是曾想過要去做那件事（例如：不知道是否曾經寄了信，還是只是想過要去寄信）。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

25. 有些人找到自己曾經做過某件事的證據，卻記不起自己曾經做過那件事。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

26. 有些人有時會在自己的物品中發現一些文章、圖畫或筆記，雖然知道應該是自己所寫和所畫的，卻記不起自己曾經寫過或畫過。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

27. 有些人有時聽到腦內有聲音叫他們做一些事，或評論他們正在做的事。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

28. 有些人有時候覺得他們好像隔着一層霧去看世界，看到的人和事物都好像很遠或不清晰的。請圈出一個數字以表示這情況有百分之幾的時間發生在你的身上。

0% 10 20 30 40 50 60 70 80 90 100%

Dissociative Experience Scale (DES). Reprinted with permission from Carlson, E. B. and Putnam, F. W. 保留所有權利. 本測驗中文版由 Cheung, M., Lam, S. S., Ma, T. M., Ng, Y. E., Poon, M. R., Wu, K. K. (2007) 經許可翻譯複印。

Appendix F

Research Version of the Children's Impact of Event Scale-Revised (CHIES-R)

事件影響量表——修訂（兒童）版（研究本）

以下所列舉的是一些人在經歷壓力事件後會出現的困難。請你把每一項目小心閱讀，然後決定這些困難在過去一星期對你產生有多大的影響，在適當的方格內畫上「✓」號。

注意：以下項目中提及的「那件事」是指 ____________________ 的有關經歷。

	完全沒有影響	少許影響	中度影響	相當大影響	極大影響	
R1.　其他事情不斷令我想那件事。						I
R2.　我覺得煩躁和忿怒。						H
R3.　我會無意中想起那件事。						I
R4.　我避開一些會令我回想起那件事的東西。						A
R5.　有關那件事的片段會突然在我腦海中出現。						I
R6.　我過份緊張和容易被嚇得跳起來。						H
R7.　我嘗試不想起那件事。						A
R8.　我不能入睡。						H
R9.　我對那件事的強烈感覺一陣一陣地出現。						I

R10. 我嘗試忘記那件事。						A
R11. 我不能集中精神。						H
R12. 遇到有關那件事的東西令我的身體產生反應，例如流汗、呼吸困難、作嘔、或者強烈心跳。						H
R13. 那件事出現在我夢中。						I
R14. 我發覺自己常常戒備小心提防。						H
R15. 我嘗試不談論有關那件事的話題。						A

I	A	H

Appendix G

Clinical Version of the Children's Impact of Event Scale-Revised (CHIES-R)

事件影響量表——修訂（兒童）版（臨床本）

以下所列舉的是一些人在經歷壓力事件後會出現的困難。請你把每一項目小心閱讀，然後決定這些困難在過去一星期對你產生有多大的影響，在適當的方格內畫上「✓」號。

注意：以下項目中提及的「那件事」是指______________________的有關經歷。

		完全沒有影響	少許影響	中度影響	相當大影響	極大影響	
C1/R2.	我覺得煩躁和忿怒。						H
C2/R3.	我會無意中想起那件事。						I
C3/R4.	我避開一些會令我回想起那件事的東西。						A
C4/R5.	有關那件事的片段會突然在我腦海中出現。						I (H)
C5/R6.	我過份緊張和容易被嚇得跳起來。						H
C6/R8.	我不能入睡。						H (I)
C7/R9.	我對那件事的強烈感覺一陣一陣地出現。						I
C8/R10.	我嘗試忘記那件事。						A
C9/R11.	我不能集中精神。						H

C10/R13. 那件事出現在我夢中。						I
C11/R15. 我嘗試不談論有關那件事的話題。						A

I	A	H

Appendix H1

Educational Kits in Relation to CSA Prevention

1.	防範有道、以保安全：預防兒童性侵犯中學教材套。香港小童群益會製作，教育署出版 (2001)
2.	保護自己、我做得到：預防兒童性侵犯小學教材套。香港明愛家庭服務製作，教育署出版 (2000)
3.	幼兒安全成長路：預防性侵犯教材套。香港小童群益會製作，教育署出版 (2000)
4.	聰明的叮噹：兒童自我保護教材套。香港青少年服務處 (2000)
5.	性教育「自我保護」教材套。匡智會 (2000)
6.	弱智人士性教育教材套。香港家庭計劃指導會 (1998)
7.	兒童性教育教材套。香港家庭計劃指導會 (1997)
8.	談情説性少年時：家長性教育資料套。社會福利署 (1997)
9.	青少年性教育教材套：性騷擾。香港家庭計劃指導會 (1996)

Index