

TSS GROUP NEWS



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March News Highlights

Anne P. DePrince, Ph.D.
TSS Group Director

2012 is well underway, with exciting updates from the TSS Group!

Thanks to partnership from many of you, we have completed recruitment for the Healthy Adolescent Relationship Project (HARP). You helped us reach out to enroll 176 young women, ages 12 to 19, into HARP. Young women enrolled in the HARP study are invited to participate in one of two 12-week programs that focuses on revictimization risk. As we reported in our last newsletter, preliminary peeks at participants' reports after the groups suggest very good news.

The final HARP prevention groups are now underway. By fall of this year, we should be able share preliminary results with you about the immediate and short term effects of the two curricula.

We are happy to report that the first of two core papers describing the impact of Triage is now available electronically from the *Journal of Consulting and Clinical Psychology (JCCP)*. JCCP is a widely-read, high impact American Psychological Association (APA) journal, which will hopefully mean good attention to the important work that the Triage team is doing! The paper will eventually appear in print as well, but this advance electronic copy is available now at: <http://mysite.du.edu/~adeprinc/DPBLBG2012.pdf>.

As you'll see, this paper documents a number of important things, including (though not limited to):

- Triage outreach linked to lower victim distress: Women in the outreach condition (relative to the standard referral condition) report lower fear, PTSD symptoms, and depression symptoms a year after our initial interview with them.

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- Triage outreach linked to greater readiness to leave abusive relationships: Women in the outreach group report greater readiness to leave the abusive partner a year after our initial interview with them than women in the standard referral group.
- Triage outreach linked to more helpful services: Though women in both groups ended up connecting with services, women in the Triage outreach group perceived the services they received as more helpful than women in the standard referral group. This may reflect that the outreach process connects women more quickly and/or more successfully with relevant services.

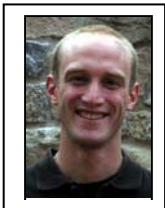
Thank you to the Triage team for their partnership on this important project.

As always, we also look forward to finding ways to work with you. Thank you for the work you do on behalf of victims and survivors.

Anne P. DePrince, Ph.D.



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Examining the Overlap between Traumatic Stress and Bipolar Disorder

Ryan Matlow, 4th Year Graduate Student

Responses to trauma vary drastically across individuals. In some cases, traumatic stress results in experiences of emotional dysregulation, depression, sleep disturbance, and symptoms of psychosis (such as hallucinations).

Interestingly, these symptoms are also core components of bipolar disorders. In particular, bipolar I disorder is characterized by episodes of mania, which consist of expansive moods, decreased need for sleep, increased goal-directed behavior, racing thoughts, and/or emotion dysregulation. Researchers studying bipolar disorders have highlighted links between trauma and bipolar I disorder through findings showing that (1) over 50% of individuals diagnosed with bipolar I disorder report a history of childhood exposure to physical or sexual abuse (e.g., Etain et al., 2010; Leverich et al., 2002), and (2) individuals with bipolar I disorder are twice as likely to also meet criteria for posttraumatic stress disorder (PTSD) relative to the general population (Assion et al., 2009; Otto et al., 2004). This overlap between traumatic stress and bipolar disorder highlights a need for improved understanding of how these two forms of psychological distress are related as well as how they interact over the lifespan.

The overlap and potential confounding of symptoms related to bipolar disorder and posttraumatic stress can present challenges for the assessment and treatment of these disorders. Previous studies have shown that PTSD is under-diagnosed in populations of patients with bipolar disorder (and other forms of severe mental illness), despite the high prevalence of trauma exposure in these populations (Assion et al., 2009; Mueser et al., 1998). In such cases, the overlap in symptom presentation may lead clinicians to focus primarily on the identification of bipolar disorder and to overlook posttraumatic stress as a contributing factor. Such oversight can be particularly problematic because approaches for treating bipolar I disorder are notably distinct from trauma-focused treatments. While bipolar I disorder is primarily treated via administration of mood stabilizing medications, approaches for treating trauma-related distress commonly emphasize exposure and narrative therapy, developing coping skills, and cognitive

restructuring. Thus, the confounding of symptoms related to bipolar disorder and trauma exposure can lead to the use of inadequate or sub-optimal interventions.

In addition, despite the high prevalence of trauma exposure and related psychopathology in individuals with bipolar I disorder, little is known about the effectiveness of trauma-focused treatments for this population. Patients with bipolar I disorder who also have a history of trauma exposure have been shown to demonstrate poorer engagement in treatment and poorer treatment outcomes, relative to patients with bipolar I who do not have a trauma history (Conus et al., 2010; Neria et al., 2002). In such cases, the experience of trauma-related distress may serve to exacerbate bipolar symptoms. Thus, there is reason to believe that trauma-focused interventions for patients with bipolar I disorder could lead to improved treatment outcomes. Indeed, because bipolar disorders and PTSD share common risk factors, targeting such factors through trauma-focused interventions may also serve to reduce bipolar symptoms. While the effectiveness of trauma-focused interventions for individuals with bipolar disorders is by no means guaranteed (and may even be detrimental, given the potential for trauma reminders to lead to mood instability), further research is needed to better understand the links between posttraumatic stress and bipolar disorders and to improve services for individuals presenting with the overlapping symptoms and history discussed above.

In the Traumatic Stress Studies Group, we are examining data from our study with adolescents presenting for treatment at community mental health clinics to explore the links between bipolar and trauma-related symptoms. This study is a unique effort to examine the prevalence of bipolar disorders and symptoms in a population of adolescents with a history of trauma exposure. We found that 33% of teens assessed for this study were diagnosed by community clinicians as having either Bipolar Disorder or Mood Disorder Not Otherwise Specified (Mood Disorder NOS; a common diagnosis for children and adolescents presenting with symptoms of

Bipolar, continued on page 3

Bipolar, continued from page 2

mania), with 17% of teens receiving comorbid diagnoses of Bipolar/Mood NOS and PTSD. In addition, bipolar I and PTSD symptom severity were strongly correlated (Pearson's $r = .39, p < .01$). In addition to examining prevalence rates, we aim to explore the specific trauma history characteristics that contribute to bipolar symptom severity. Preliminary results indicate that trauma exposure is significantly associated with bipolar symptom severity, and that histories of childhood psychological and sexual abuse are each uniquely related to bipolar symptom severity. By establishing links between bipolar diagnoses and trauma exposure, we hope that this research will set the stage for future studies aimed at improving the assessment and treatment of individuals with a trauma history who present with symptoms of bipolar disorder.

References

- Assion, H. J., Brune, N., Schmidt, N., Aubel, T., Edel, M. A., Basilowski, M., ... Frommberger, U. (2009). Trauma exposure and post-traumatic stress disorder in bipolar disorder. *Society of Psychiatric Epidemiology*, *44*, 1041–1049.
- Conus, P., Cotton, S., Schimmelmann, B. G., Berk, M., Daglas, R., McGorry, P. D., Lambert, M. (2010). Pretreatment and outcome correlates of past sexual and physical trauma in 118 bipolar I disorder patients with a first episode of psychotic mania. *Bipolar Disorders*, *12*, 244–252.
- Etain, B., Mathieu, F., Henry, C., Raust, A., Roy, I., Germain, A., ... Bellivier, F. (2010). Preferential association between childhood emotional abuse and bipolar disorder. *Journal of Traumatic Stress*, *23*, 376–383.
- Leverich, G. S., McElroy, S. L., Suppes, T., Keck, P. E., Denicoff, K. D., Nolen, W. A., ... Post, R. M. (2002). Early physical and sexual abuse associated with an adverse course of bipolar illness. *Biological Psychiatry*, *51*, 288–297.
- Mueser, K. T., Goodman, L. B., Trumbetta, S. L., Rosenberg, S. D., Osher, F. C., Vidaver, R., ... Foy, D. W. (1998). Trauma and posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology*, *66*, 493–499.
- Neria, Y., Bromet, E. J., Sievers, S., Lavelle, J., & Fochtmann, L. J. (2002). Trauma exposure and posttraumatic stress disorder in psychosis: findings from a first-admission cohort. *Journal of Consulting and Clinical Psychology*, *70*, 246–251.
- Otto, M. W., Perlman, C. A., Wernicke, R., Reese, H. E., Bauer, M. S., & Pollack, M. H. (2004). Posttraumatic stress disorder in patients with bipolar disorder: a review of prevalence, correlates, and treatment strategies. *Bipolar Disorders*, *6*, 470–479.



TSS Group Achievements

Students in our clinical psychology program are required to complete a one-year internship prior as part of the PhD degree. Clinical internship placements are extremely competitive. We are proud to announce that **Claire Hebenstreit** matched with Palo Alto Veteran's Administration and **Ryan Matlow** matched with Child and Adolescent Services at the San Francisco General Hospital of University of California, San Francisco. They will begin their internships later in the summer.

Becca Babcock and **Jane Sundermann** received Graduate Studies Doctoral Fellowships for Inclusive Engagement from the University of Denver.

We are pleased to announce several new publications now available at

<http://mysite.du.edu/~adeprinc/pub.html>:

DePrince, A. P., Labus, J., Belknap, J., Buckingham, S., & Gover, A. (2012, February 13). The Impact of Community-Based Outreach on Psychological Distress and Victim Safety in Women Exposed to Intimate Partner Abuse. *Journal of Consulting and Clinical Psychology*. Advance online publication. doi: 10.1037/a0027224

Matlow, R. B., & DePrince, A. P. (2012, March 12). The Influence of Victimization History on PTSD Symptom Expression in Women Exposed to Intimate Partner Violence. *Psychological Trauma: Theory, Research, Practice, and Policy*. Advance online publication. doi: 10.1037/a0027655

Goldsmith, R., Freyd, J.J., & DePrince, A.P. (2012) Betrayal trauma: Associations with psychological and physical symptoms in young adults. *Journal of Interpersonal Violence*, *27*, 547–567.

DePrince, A.P., Brown, L.S., Cheit, R.E., Freyd, J.J., Gold, S.N., Pezdek, K. & Quina, K (2012). Motivated forgetting and misremembering: Perspectives from Betrayal Trauma Theory. In Belli, R. F. (Ed.), *True and False Recovered Memories: Toward a Reconciliation of the Debate (Nebraska Symposium on Motivation 58)* (pp 193–243). New York: Springer.





Emotional Nonacceptance and Mental Health Symptoms Among Victims of Violence

Jane Sundermann, 3rd Year Graduate Student

Note: The following article summarizes key points from a manuscript under review (Sundermann, Chu, & DePrince, under review).

The TSS Group has a long-standing commitment to research that investigates links between exposures to interpersonal trauma (e.g., intimate partner violence, maltreatment, etc.) and risk for mental health difficulties. We've also been interested in how a range of factors—from environmental (e.g., police response, social support) to incident (e.g., victim-perpetrator relationship) and victim (e.g., executive function, relationship schemas) factors—can help us understand links between violence exposure and mental health outcomes. In a previous newsletter (October 2010), we highlighted how difficulties with emotion regulation (ER) may relate to the development or maintenance of mental health symptoms among youth victims of maltreatment. Extending our work with youth, we recently examined similar relationships between ER and mental health symptoms in adult victims of violence. Studying mental health outcomes in both youth and adults can help us discover new insights about the developmental and cumulative effects of interpersonal violence on victims' lives. Unfortunately, victims of chronic interpersonal trauma (trauma experienced across the lifetime) are often understudied in research.

To address this research gap, we tested links between women's cumulative violence exposure (across childhood and adulthood), a particular form of ER difficulty (emotional nonacceptance), and mental health symptoms (including depression, dissociation, and Posttraumatic Stress Disorder symptom severity). The data was collected from a sample of 94 women exposed to interpersonal violence. This sample was recruited several years ago with help from the **Victim Assistance Unit** of the Denver Police Department.

Emotional nonacceptance, a dimension of overall ER difficulty, refers to a general unwillingness to experience emotions (Hayes et al., 2004), including avoidance of emotional states or strong secondary and judgmental reactions to those emotions (e.g., feeling guilty about

being sad or angry).

Results revealed that women who reported more cumulative violence exposure also reported greater emotional nonacceptance. Together, women's reports of lifetime exposures to violence and emotional nonacceptance predicted more severe symptoms of depression, dissociation, and PTSD. These data are cross-sectional (collected at one time point). Thus, from these analyses alone, we cannot make definitive statements about the directions of effects (do mental health symptoms increase emotional nonacceptance...or does emotional nonacceptance increase mental health symptoms?) or how the variables influence each other over time. However, the findings encourage us towards further research that can better explore the relationships between violence exposure, ER difficulties like emotional nonacceptance, and important mental health outcomes.

Interventions that target ER difficulties, such as emotional nonacceptance, among victims of trauma are increasingly available and supported by intervention studies (e.g., TF-CBT; Cohen, Mannarino, & Deblinger, 2006). We look forward to finding ways to combine our basic research with intervention studies to better understand how enhancing ER skills can contribute to victims' and survivors' empowerment and healing, especially in the aftermath of cumulative and chronic trauma.

References

- Cohen, J.A., Mannarino, A.P., & Deblinger, E. (2006). *Treating Trauma and Traumatic Grief in Children and Adolescents*. New York: Guilford Press.
- Gross, J.J., & Thompson, R.A. (2007). Emotion regulation: Conceptual foundations. In J.J. Gross (Ed.), *Handbook of emotion regulation* (pp. 581 – 605). New York: Guilford Press.
- Hayes, S. C., Strosahl, K., Wilson, K. G., Bissett, R. T., Pistorello, J., Toarmino, D., & McCurry, S. M. (2004). Measuring experiential avoidance: a preliminary test of a working model. *The Psychological Record*, 54(4), 553–578.





THANK YOU FROM HARP!

It takes a village! To do research, that is.

Thank you to the many people and agencies who helped us enroll over 175 teens into the Healthy Adolescent Relationship Project (HARP), including (but not limited to):

Lacey Alesch	Valerie Arguello-Perez	Marci Ascherman	Mari Amarillo
Mary Berg	Ashley Bertsch	Andrea Bradford	Peggy Baikie
Sarah Blaine	Angela Borkowski	Angela Bradford	Jessica Brogger
Margie Brunner	Tricia Buddy	Jessica Bueno	Deborah Canlas
Lori Carlson	Melissa Carson	Carr Group Home Staff	Tina Carter
Sarah Cashion	Kristen Caswell	Ally Coleman	Erin Coloroso
Cynthia Conner	Mandy Copeland	Shanon Copeland	Keith Crosson
Dawn Crosswhite	AnnaMarie Dalton	Trisha Daly	Michael Degretto
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Nicole Jerving			
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Tracy Neely	Carrie Nickles	Karin Nystrom	Kristin O'Gowan
Kelley Oakley			
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Tandi Schips			
Tracey Schlafer	Kristin Schmidt	Anna Schneider	
Sexual Assault Interagency Council		Shiloh House Staff	Brittany Sievers
Courtney Smith	Molly Somogyi	Sandra Stanger	Heather Taussig
Third Way Center Staff	Lauren Timkovich	Sera Treston	
Victim Services Network	Julie Trim	Jaime Trujillo	Margo Vanhaeck
Elizabeth Walters	Susie Walton	Kathryn Wells	Derek Williams
Edie Winters	Jerry Yager		

Getting to Know our Newest TSS Group Member

*Please join us in welcoming **Tejas Srinivas** to the TSS Group. Tejas, a first year graduate student in the Child Clinical Psychology program, joined us in the fall. We asked her a few questions to help you get to know her.*

Q: Tell us about yourself, please!

Tejas: I was born in India and moved to the US when I was five years-old. I have strong northeast roots (grew up in New Jersey, went to college in Connecticut, and lived in New York City and Boston after graduation), but I'm already falling in love with the sunshine and natural beauty of Colorado. After pursuing my undergraduate degree in Political Science and Philosophy at Yale, I realized that I was most interested in researching the psychological consequences of violence, and especially posttraumatic distress. My transition to the psychology world involved researching posttraumatic stress disorder and substance use disorder at the Mount Sinai Mood and Anxiety Disorders Program and the Boston VA Medical Center. These experiences solidified my commitment to researching trauma, particularly in relation to women and children, refugees, minorities, and survivors of political violence. Apart from my academic interests, I enjoy playing tennis and violin, watching foreign films, and indulging in international food.

Q: What are your current research interests?

Tejas: Generally, I am interested in the role of cognitive appraisals in the development of posttraumatic distress following exposure to violence. For my master's thesis, I am examining how procedural justice impacts the psychological outcomes of survivors of intimate partner abuse (including survivors' posttraumatic appraisals and distress). I also hope to research cross-cultural differences in the cognitive processing of trauma, the



Welcome
Tejas!

differential importance of various cognitive appraisals in the aftermath of political trauma, and the role of cognitive appraisals in relation to posttraumatic growth.

Q: What drew you to the TSS group?

Tejas: I was initially drawn to the TSS group because of the breadth of research tracks pursued within the lab as well as the explicitly community-based nature of the research. After interview weekend, I was also excited by the high level of support and collaboration within the group.

Q: What do you hope to accomplish in the TSS group?

Tejas: I'm excited to have the opportunity to join and learn from such an enthusiastic and collaborative group! In terms of research projects, I'm enjoying contributing to the Healthy Adolescent Research Project (HARP) and look forward to helping with the Women's Justice Project with survivors of domestic human trafficking. In general, I'm looking forward to learning more deeply about the role of cognitive appraisals in relation to posttraumatic distress as well as to posttraumatic growth.

Finally, I am looking forward to helping with applying the group's research to the broader community and to more diverse populations at home and abroad.



We are pleased to announce that **Kerry Gagnon** accepted our offer to join the TSS Group in Fall 2012 as a first year student in the Child Clinical Program. We look forward to introducing you to Kerry in the next academic year!