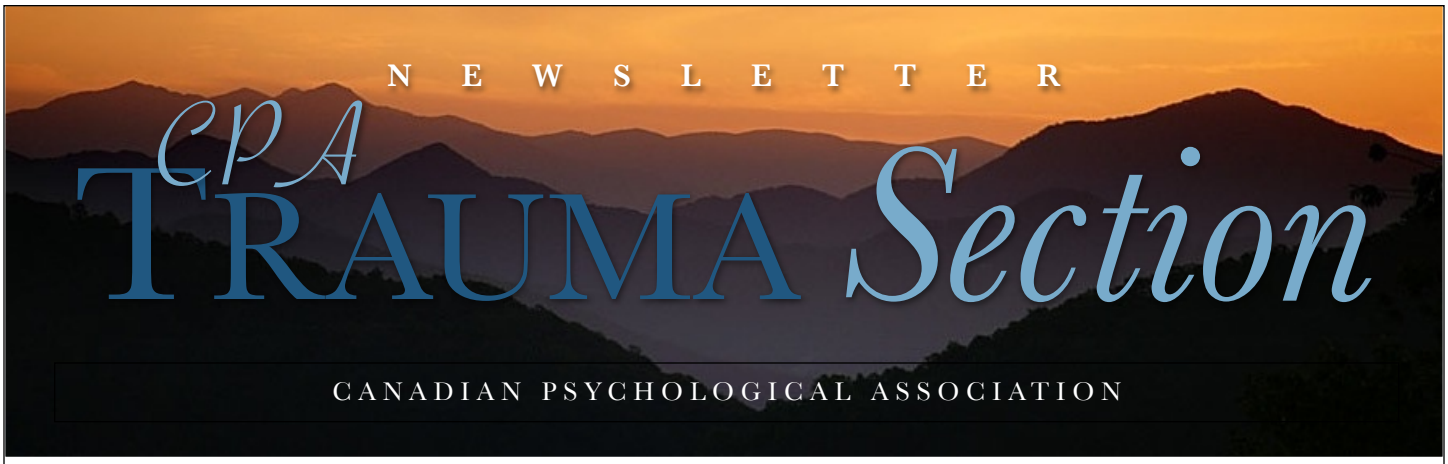


NEWSLETTER

CPA TRAUMA Section

CANADIAN PSYCHOLOGICAL ASSOCIATION

In This Issue:

Dear members of the CPA Traumatic Stress Section (TSS):

I hope you are making the best of this «rentrée» and are returning from your well deserved vacations refreshed and enthusiastic to make the world a better place to live. This issue of our newsletter is dedicated to novel pharmacological treatments of traumatic stress. I encourage you to give us your opinion on the clinical, research, and ethical issues pertaining to the use of medication as a sole or complementary treatment for traumatic stress.

As usual, you are welcome to give us your feedback and to advise us of any related news, upcoming events, job listings and recent publications you would like to be published in the next newsletter.

Please do not hesitate to contact the executive committee members of CPA TSS as we remain committed to serving your needs and interests.

Alain Brunet, Ph.D., Chair
Traumatic Stress Section

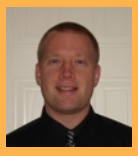
Section News

By Anne Dietrich, Ph.D. and Alain Brunet, Ph.D.

Our Team

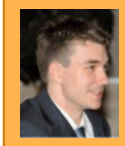
Alain Brunet PhD, Chair

Anne Dietrich, PhD Past Chair



Paul Frewen, PhD Chair-Elect

Deniz Fikretoglu, PhD, Treasurer



Nick Carlton, PhD Newsletter Editor

Marianne Pelletier &

Nelson Azoulay, Student Representatives

The executive committee has been very productive and busy over the past few months. We have exciting plans over the next year.

Membership

Membership has increased by 15% over the past year. We want to thank everyone who invited new members to become part of our growing section. The number of current members is 303, with approximately 80 of these being students.

Election

Elections were held in May/June, with the following results:

Chair:	Alain Brunet (continuing)
Chair-elect	Paul Frewen (newly elected)
Past chair:	Anne Dietrich (continuing)
Treasurer:	Deniz Fikretoglu (continuing)
Student reps:	Marianne Pelletier and Nelson Azoulay (newly elected)

Ad hoc members

Nick Carleton	(Newsletter Editor) (appointed)
Elena Saimon	(Webmaster and various other tasks) (appointed)

Dr. Frewen will become section Chair at the next annual business meeting in June of 2011. Congratulations to Dr. Frewen, and to Ms. Pelletier and Mr. Azoulay on their elections to the section! We also extend a warm welcome to Deniz Fikretoglu, who was elected last year and is replacing Colleen Haney. Best wishes to Colleen who has served as Treasurer for our section for many years. Thank you, Colleen for your many years of devoted service!

TSS & ISTSS Affiliation

As of February 8, 2010 the Traumatic Stress Section of the CPA achieved affiliate status with the International Society for Traumatic Stress Studies (ISTSS). Anne Dietrich published an article about the Traumatic Stress Section aims, structure, and activities in the Spring edition of the ISTSS newsletter, *StressPoints*.

As a result of this affiliation, the members of CPA TSS have the following benefits:

- Discount on ISTSS membership or on a subscription to Journal of Traumatic Stress.
- Reduced registration rates at the ISTSS Annual Meeting (which match those offered to ISTSS members).
- The same benefits as full ISTSS members with regard to financial aid opportunities such as membership subsidies, conference registration waivers, and travel grants.
- ISTSS endorsement of CPA conferences and other professional activities.
- CPA may publish informational articles and announcements without cost in the ISTSS newsletter, StressPoints.

Section News Continued

- Opportunity for cost-free or at-cost postings on the ISTSS website, subject to normal ISTSS website governance procedures.
- Opportunity for the CPA President (or his/her nominee) to hold an ex-officio (non-voting) position on the ISTSS Board of Directors.

Use of the ISTSS mailing list once per year at no cost and of the ISTSS email distribution list on a reasonable basis.

We encourage members of the TSS to check out the ISTSS website (www.istss.org) and give consideration to becoming members of the ISTSS. Each year the ISTSS holds an outstanding conference, with the top international researchers and clinicians presenting their work.

We strongly encourage TSS members to attend the ISTSS convention in Montreal this November. It promises to be an excellent conference. Please see the ISTSS website for more information (http://www.isstss.org)

Annual Convention Business Meeting

The CPA Annual Convention was held on June 3-5, 2010 in Winnipeg. The Traumatic Stress Section held its business meeting on June 3.

Website

The Traumatic Stress Section website has been maintained and updated. Additionally, the following psychosocial documents to assist disaster mental health workers has been added:

• Psychosocial Documents to Assist Disaster Mental Health Workers:

• Manual to assist in planning the delivery of psychosocial services.
• Manual to assist in planning and managing the delivery of emergency social services in a mass shelter.
• Manual to assist in planning and managing the delivery of food in a mass shelter.
• Brochure on how to help children aged 1-6 and 7-1 after a disaster.
• Brochure on how to help adolescents cope after a major disaster.
• Brochure on how to look after ourselves, our family and our community when a major disaster strikes.

The above documents were utilized and appreciated by many disaster health professionals, including those working in Haiti in the aftermath of the earthquake.

TSS Objectives for the Next Year

- Newsletter publication on a bi-annual basis.
- Participation of the members of CPA TSS in the ISTSS conference, to be held in November 2010 in Montreal. TSS members will have a booth to highlight CPA and the TSS at the ISTSS conference.
- Recruitment of a speaker for the next (2011) CPA convention.
- New member recruitment.




Upcoming Events

• 2010 ISSTD Annual Conference
October 16 -18, 2010
Atlanta Hilton Hotel
Atlanta, Georgia, USA
www.isst-d.org/annual_conference/2009/index.htm

• ISTSS 26th Annual Meeting
November 4-6, 2010
Le Centre Sheraton Montreal Hotel, Montréal, Québec, Canada
www.istss.org/meetings/

CPA Traumatic Stress Section members have a rebate registering for the ISTSS conference
https://web.cpa.ca/membership/
Join the CPA Traumatic Stress Section

Non-psychologists can also join the CPA as special affiliates
www.cpa.ca/members/membershiptypes/specialaffiliate/

• Region's Conference of ESTSS
December 2 - 3, 2010
Cardiff, United Kingdom
www.estss.org/confer/conf_files/cardiff_2-3_12_10.pdf

• San Diego's International Conference on Child and Family Abuse
January 22 - 28, 2011
San Diego, California, USA
www.sandiegoconference.org

• 1st Global Conference on Trauma: Theory and Practice
March 14 - 16, 2011
Prague, Czech Republic
www.inter-disciplinary.net/at-the-interface/evil/trauma/call-for-papers/

• Alberta's 5th Biennial Conference For Acquired Brain Injury
March 17 - 19, 2011
Calgary, Alberta; at the Hyatt Regency Calgary
biaa.ca/abic2011/

• European 12th Conference on Traumatic Stress
June 2 - 5, 2011
Vienna, Austria
http://ecots2011.univie.ac.at/index.php?id=52841

Pharmacological Treatment of PTSD: what's new?

By Nick Carleton, Ph.D.

The challenging and pernicious nature of posttraumatic stress disorder (PTSD) necessitates exploration of a variety of treatment options, including pharmacotherapies. A recent review (Cukor, Spitalnick, Difede, Rizzo, & Rothbaum, 2009) of PTSD treatments provided supportive evidence from several investigations of the impact of pharmacotherapy for treating PTSD. D-cycloserine, Ketamine, Prazosin, Methylenedioxymethamphetamine, and Opiates have been among the major pharmacotherapies of interest to research and clinicians.

D-cycloserine

There is growing evidence supporting the use of D-cycloserine as an effective adjuvant for exposure therapies. Current research suggests D-cycloserine facilitates extinction of fear, leads to generalized extinction and reduces relapse after re-exposure to the feared stimuli. The recent review (Cukor, et al., 2009) covered social phobia (Hofmann et al., 2006) and panic (Otto et al., 2009), but there is also evidence for using D-cycloserine in exposures therapy for simple phobias (Ressler et al., 2004) and obsessive compulsive disorder (Abramowitz, Taylor, & McKay, 2009). As such, it is reasonable to expect that D-cycloserine will be similarly effective for patients with PTSD. Ongoing investigations have begun exploring the efficacy of D-cycloserinefor PTSD (Cukor, et al., 2009) and we look forward to further results in this area.

Ketamine

The evidence for the use of Ketamine – a non-barbiturate anaesthetic – has been mixed. There is some evidence suggesting Ketamine lowers PTSD symptoms and may cause a disruption to memory processes. In contrast, there are also results that Ketamine increases symptoms of acute stress, possibly through psychotic and dissociative symptoms. To date, researchers investigating Ketamine and PTSD have suggested that the available evidence should be interpreted with caution because of methodological concerns and indicated further research is needed.

Prazosin

Increases in norepinephrine have been implicated in poor sleep and nightmares, both significant symptoms associated with PTSD. Prazosin has been demonstrably associated with symptom-specific improvements in sleep and reductions in nightmares. The research to date has focused on men in military populations but is being expanded to include civilian populations. Future research should include randomized controlled trials to demonstrate a stronger causal relationship.

Methylenedioxymethamphetamine

More commonly known as Ecstasy, this drug has recently been approved for clinical trials as an adjuvant for treating chronic PTSD. The premise is that the mood-enhancing properties during exposure therapies may facilitate positive consolidations of memories or increase the strength of therapeutic rapport; however, there have also been reports of the drug inducing negative moods states, psychological distress, and problems associated with the use of a central nervous system stimulant in a psychiatric population. Given available alternatives, the uncertainty by which this medication exerts its effects, and the associated risks, caution is warranted in proceeding with the exploratory use of this substance for PTSD.

Opiates

There has also been a recent pharmacological investigation of morphine for PTSD. The relationship between chronic pain and PTSD has been increasingly well-established. Indeed, mutual maintenance models have been proposed that demonstrate how the comorbidity of both disorders may develop (Asmundson, Coons, Taylor, & Katz, 2002; Sharp & Harvey, 2001). In short, certain components of PTSD (i.e., physiological, affective, and behavioural) maintain or exacerbate chronic pain symptoms; conversely, certain components of chronic pain (cognitive, affective, and behavioural) maintain or exacerbate PTSD symptoms. People can thereby become trapped in a vicious cycle in which the symptoms of each disorder interact to produce self-perpetuating distress and functional disability. Interventions designed to prevent acute pain (post

injury) from becoming chronic have proven effective in reducing the impact of chronic pain when initiated early in the pain process (Cole, 1998; Hadjistavropoulos, Asmundson, & Kowalyk, 2004; Linton, 1998; Linton et al., 2008; Jeanine A. Verbunt et al., 2003; J. A. Verbunt, Sieben, Vlaeyen, Portegijs, & Andre Knottnerus, 2008). Accordingly, similar interventions can be expected to reduce the probability an injured person will develop PTSD. Holbrook and colleagues (2010) explored the impact of morphine administrations for injured veterans who had returned from Iraq. Patients who morphine demonstrated a seemingly robust significantly lower risk for developing PTSD. As such, the mechanisms of mutual maintenance supporting PTSD appear to be malleable through active reductions of acute pain in traumatically injured individuals.

Overall, there appears to be growing promise for the use of pharmaceuticals in the treatment of PTSD. Current research data or as treatments per se lends some support to the use of such pharmacotherapies as adjuvants. Future research should continue to explore the potential benefits of each pharmacotherapy for the variety of symptom patterns recognized within PTSD.

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Propranolol and PTSD: Clinical Implications and Future Directions

By Laura Armstrong, C. Phil.

Intense physiological arousal in response to trauma cue exposure is one of the hallmarks of Posttraumatic Stress Disorder ([PTSD] APA, 2004). In Pavlovian terms, trauma cues, or reminders of the traumatic event, are conditioned stimuli. These conditioned stimuli elicit conditioned physiological arousal responses as a function of excessive emotional memory for traumatic events in PTSD (Giles, 2005; Stone, 2005).

A number of researchers are beginning to use propranolol, a β-adrenergic blocker, as a way of dampening such conditioned response in individuals exposed to trauma or those diagnosed with PTSD (e.g., Brunet et al., 2008; Cahill, Prins, Weber, & McGaugh, 1994; Nugent et al., 2010; Pitman et al., 2002; Taylor, 2005). According to the Canadian Mental Health Association (2008), approximately 8% of people will suffer from PTSD in their lifetime.

RESEARCH ON PROPRANOLOL

Early research on the use of propranolol suggested that the β-adrenergic stress hormone systems are activated during and following an emotional experience (Cahill et al., 1994). Specifically, one hour after administering propanolol or a placebo, Cahill at al. presented adult participants with two stories, one emotionally neutral and one emotionally arousing. Impaired memory for the emotionally arousing story was found in participants who were administered propranolol, by contrast to those who received placebo. Propranolol also decreased heart rate and blood pressure. No effect of propranolol on memory for the emotionally neutral story was found.

Complementing this research, propranolol administered within six hours of a traumatic event reduced physiological responses to mental imagery of the event (Pitman et al., 2002). A case study was also carried out with an adult patient who experienced multiple motor vehicle accidents and exhibited progressively worse PTSD symptoms following each accident, despite counseling and psychopharmological treatment (Taylor, 2005). Within 48 hours of her sixth accident, the patient received 60 mg of propranolol daily and her symptoms improved significantly. Her symptoms relapsed after the propranolol was discontinued at two months. Propanolol was re-administered and subsequently discontinued at three months, resulting in ongoing symptom improvement. Taylor concluded that, for some individuals, propranolol might be an effective preventative measure for PTSD or trauma-related symptoms if administered within a short time period following a traumatic event.

Although there appears to be a narrow period of time during which β-blockers can attenuate fear conditioning and encoding of emotional memory (Ji, Wang, & Li, 2003), Brunet et al. (2008) proposed that the window of opportunity for the administration of propranolol could be re-opened to weaken the physiological response. Brunet et al. randomly assigned adult participants with PTSD to a propranol group and a placebo group. Both groups prepared personal trauma scripts, following Pitman et al.'s (1987) script-driven imagery procedure. Following the imagery script presentation, participants received placebos or 40 mg of short acting propranolol and then, 2 hours later, 60 mg of a long-acting propranolol. Physiological responses, measured as heart rate and skin conductance, were significantly lower in the propranolol group by comparison to the placebo group. The results of the Brunet et al. study suggest that propranolol given after memory retrieval of a past traumatic event reduced the physiological fear response.

The fear response, acquired through the formation, consolidation, and long-term retrieval of memories formed during times of stress, is thought to be dependent upon the amygdala and related mediotemporal structures (Cahill, 2003; Cahill et al., 1994; Chamberlain, Müller, Blackwell, Robbins, & Sahakian, 2006; Strange & Dolan, 2004; van Stegeren et al, 2005). Research using functional Magnetic Resonance Imagery [fMRI] technology has indeed found that encoding of emotionally aversive nouns or aversive pictures engages the left amygdala and left hippocampus, but this activation can be

abolished with propranolol (Strange and Dolan, 2004; van Stegeren et al., 2005). By contrast to these favourable results with adults, the use of propanolol for pediatric injury patients at risk for PTSD has not been as promising (Nugent et al., 2010). Following admission to the hospital, children at risk for PTSD and those meeting risk criteria were randomized to a propranolol or placebo group. Propranolol (20 mg, twice daily) or placebo was initially administered within 12 hours of admission. At six weeks following injury, the Pitman et al. (2002) script procedure was followed and physiological measures were taken, heart rate and blood pressure. No overall treatment group results were significant. However, by gender, females in the propranolol group indicated significantly more PTSD symptoms than those in the placebo group. It remains possible that the dose of medication was too low and that it was given after the withdrawel opportunity for blocking consolidation had expired. Conversely, there was a non-significant trend for males in the propanolol group to report fewer symptoms than the placebo group.

FUTURE DIRECTIONS

Differing research findings could be a function of time of drug administration (e.g., is there a specific window for propranolol to be effective?), whether the effects are enduring, optimal dosage, gender, or trauma history. Recent research has yielded findings to suggest increased autonomic responding to trauma stimuli in single-trauma victims but blunted physiological responding to trauma stimuli after multiple trauma exposures (McTeague et al., 2010). Thus, the effects of propranolol may differ between single and multiple trauma victims. Taken together, emerging findings on the use of propranolol for the prevention or treatment of PTSD suggest that this β-adrenergic blocker may be beneficial for some individuals, at certain doses, and potentially within a finite window of time following trauma or trauma-related imagery. Noradrenergic pathways are clearly implicated in memory encoding and physiological responses to trauma. Thus, further research to clarify the usage of propranolol could refine treatment protocols for PTSD.

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Propranolol Research: Ethical Issues

By Elena Saimon, B.A.

The advent of new pharmacological treatments for PTSD has stirred a lively discussion on the underlying ethical issues of such interventions. In 2003 the President's Council on Bioethics voiced their concerns in 'Beyond Therapy', opposing the medical treatment for psychological conditions, PTSD specifically. Here is an excerpt from the book:

… By directly inducing changes in our subjective experience, the new psychotropic drugs create the possibility of severing the link between feelings of happiness and our actions and experiences in the world. Who would need better children, superior performance, or more youthful bodies if medication could provide the pleasure and sense of well-being that is the goal of so many of our aspirations? Indeed, why would one need to discipline one's passions, refine one's sentiments, and cultivate one's virtues, in short, to organize one's soul for action in the world, when one's aspiration to happiness could be satisfied by drugs in a quick, consistent, and cost-effective manner?

They go as far as proposing that '*Lady Macbeth, cured of her guilty torment, would remain the murderess she was, but not the conscience-stricken being even she could not help but be*'.

Overall, they raised concerns about loosing or crippling one's identity and moral grounds in the pursuit of a cure from a disorder. Furthermore, in the framework of prevention, they question the ability of the medical community to judge when and under what circumstances treatment is merited and who should receive the treatment. They especially emphasize the latter concern within the context of eye witness testimony given the fragility of memory accuracy when treated with a memory altering drug. Yet another concern raised by the Council relates to the possibility of 'persistence of related symptoms of trauma that has not been adequately confronted'.

TO TREAT OR NOT TO TREAT?

Much of this discussion on ethical issues associated with pharmacological treatment revolves around the use of propranolol for the treatment of PTSD. Propranolol is a non-selective beta-adrenergic receptor blocking agent. Traditionally recommended for certain heart conditions, it reduces excessive sympathetic nervous system activity. The interest in using this drug has been growing rapidly. Recently, however, this interest, based on emerging but promising evidence of the effects of propranolol on reconsolidation of traumatic memory, prompted major North American and European universities to comprehensively study the use of propranolol in the treatment of PTSD. The initiative is notably supported by the US department of defence.

Beta-adrenergic blocking drugs have been used for nearly 50 years (Scriabine, 1979). Their anxiolitic properties were discovered in the early seventies (Bonn et al, 1972). The advantage of these drugs comes from the fact that they do not interfere with cognitive functioning or cause dependence (Hartley et al, 1983). Recent research indicates that propranolol can affect the traumatic memory by subsiding the intensity of its emotional component (Brunet et al., 2008; Pitman et al. 2002).

Supporters of pharmacological and specifically propranolol treatment argue that some of the concerns raised by the Council are related to the everyday use in the general public and not to the specific population affected by PTSD (Donovan, 2010). Donovan believes that there exist two categories of ethical issues related to propranolol: research and clinical. The biggest issue pertaining to research involves the obvious impossibility of designing ecologically valid experiments which test human reaction to traumatic experience.

However most of the concerns related to the use of propranolol belong to the clinical sphere. Using propranolol to prevent the development of symptoms of PTSD raises the issue of our poor ability to predict who will develop PTSD following trauma. A separate but related issue concerns the ability of individuals to provide informed consent for such preventative treatments. Donovan points out that the minimal side-effects of propranolol cause no harm when using it for prevention. She refutes the biggest concern raised by the council regarding the loss of identity following pharmaceutical intervention, arguing that individuals suffering from PTSD have already lost their sense of

self when their condition interferes with their functioning, stability and well-being. On the contrary, the use of propranolol in such a condition may actually restore the prior identity of individuals by relieving their emotional burden.

Furthermore, Donovan argues that missing in this argument are ideas of malleable and decaying memory, and of individual identity that is not static, but evolving over time. Thus, given these transformational abilities, the argument that a change introduced by the drug to relieve psychological pain can have negative implications does not hold in this context.

Donovan also points out that the scenarios in which the witness of a crime takes pills to ease the intensity of the painful memory are unrealistic, as the drugs are not easily available like Tylenol, but can only be obtained with a prescription. When it comes to people planning criminal acts and taking drugs to subside their affect, it is necessary to mention that there is no evidence to this day that propranolol has any affect on the feeling of guilt.

CONCLUSION

Trachman (2007) argues against the 'disease mongering' view of propranolol use by bringing attention to the fact that not everybody can cope, confront his/her feelings and grow from traumatic experience. This raises the question whether we have the moral right to deprive these people who are seriously affected by their PTSD of a relatively easy and time efficient treatment. Moreover, people suffering from PTSD are more likely to self-medicate with alcohol or recreational drugs (Hoge et al. 2004). The use of propranolol might reduce these destructive behaviours (Hall & Carter, 2007).

Finally, the use of propranolol for the treatment of PTSD has received a misleading reputation as being a treatment of 'memory erasal'. In fact, it is believed that the drug dissociates the emotional aspect of the memory from the memory itself, thus freeing the psyche from a burden of painful intrusive memories.

Nonetheless, the jury is still out on the pharmacological treatment of traumatic stress disorder which can alter memory. It is important that the questions about safety and wellbeing of people are raised and it is equally important to conduct research on the subject. We would like to know your opinion on the use of medical products for the treatment of psychological disorders and PTSD specifically. We will publish your remarks in the opinion section of our next newsletter.

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Opinion Section
Model of Care and Post Traumatic Growth

By Yaya de Andrade, Ph.D.

More than 3 decades ago, I embarked on the study of trauma and the practice of psychotherapy with survivors of torture and other individuals who had direct traumatic experiences. My learning experiences are two-handed. On the one hand I learn (and sometimes unlearn) from colleagues, psychotherapists and researchers who work in similar and diverse contexts. On the other hand I continue to be surprised by how much clients, students and those I provide training to share their ideas and experiences, their coping mechanisms, the support given to them, and the challenges they face after traumatic experiences.

New frontiers and findings are constantly emerging, best practices are being established, and on-going opportunities to meet face to face with individuals are continually opening up new perspectives through shared stories.

The role of therapists is ever expanding as we witness situations where communities are destroyed by political conflicts and natural disasters.

In the privacy of the therapy room it is not always easy to listen to stories, even though it may not be difficult for clients to tell about their experiences. We offer hope and specific knowledge that may help them cope with the aftermath of their traumatic experiences. We offer particular methods that will help many alleviate their intrusive thoughts and reduce tendencies to avoid painful reminders of the experiences. We learn to contain and to try to make sense of the complex features they report and describe, especially those that make their daily routine unbearable.

A MODEL OF CARE

Currently I convey to clients as part of a model of care that there are 3 things we all learn through life: (1) that we have *some* control, (2) over *some* things, (3) *some* of the time. Self- evidently there are many things one *can* control, and these controllable factors constitute the focus of the work of most therapists, they constitute the major reason for providing psychological services after traumatic experiences. Yet our role as therapists is not only to help clients better understand their symptoms and the long term impact of post traumatic stress, but also to help them accept that traumatic experiences are unlikely to be deleted from one's cortex, and one must live and can live well after horrible experiences.

There are many contemporary examples of people who have turned their lives around, despite their horror, pain and losses. Their lives are beneficial to many in ways they would have never thought possible beforehand. Nelson Mandela and Rick Hansen are examples of such individuals. Both have learned to deal with traumatic events and subsequent experiences that could and did change their lives, the lives of others around them, and both continue to demonstrate that there is recovery, integration and adaptation post trauma. They represent the best in humanity, resilience, understanding and courage.

The field of traumatic stress continues to expand, and there is an avid interest in finding out why many people recover from traumatic experiences while some succumb. This complex question is posed on TV shows, in magazines and uncountable books as well as academic journals describing research projects and case studies. For instance, the likely addition of a new DSM-V category, d*evelopmental trauma disorder,* will be a helpful and relevant conceptualization alongside *post traumatic stress disorder*.

Scholars like psychiatrist Bessel van der Kolk are trying to show that individuals who have lived with pervasive violence and violations from an early age may feel an impact that is long lasting and far more complex than is currently acknowledged. Likewise, psychologist Martin Baro spent his professional life emphasizing the importance of understanding the psychosocial context of traumatic experiences. Contexts where social polarization, institutional lies, violence and violations are imposed result in pervasive psychosocial trauma of individuals, families and communities. Those who live and relate in such contexts may feel that their personal reality is unreal, particularly when directly contradicted by

official reports. The historian Joan Simalchik points out that the real narrative history is differently understood by victims and victors.

In the health field, it is known that what is relevant in recovery is *not only the treatment* provided for a particular condition, but *how the person perceives* having such a condition. There are uncountable cases of individuals with terminal diseases and long lasting difficulties who continue to have a quality of life that surprise their caregivers, and certainly their service providers. On the other hand there are those who cannot tolerate pain, whose threshold for discomfort does not permit them to see positive aspects in their surroundings. As we all witness, at a distance, the impact of disaster such as the earthquake in Haiti, it is beneficial to remember that there are heroes, people who will thrive despite their losses and the destruction around, but there are also those who will need assistance to deal with the impact of their traumatic experiences.

Each person comes to us with a particular experience, family life, and culture. Each of these aspects has so many details that one cannot reduce them to a simple equation along the lines of "if this happened to you, you likely have this" and "if you get this or do this, you likely will get better". But what is better? For some sleeping well is the priority, for others it may be to be able to love again, to trust and to be curious about life.

CONCLUSION

Like my colleagues, I have introduced mindfulness as part of a model of care which already focuses on a process of being with others, knowing that we are affected by what happens to us and to loved ones. It is important to understand that we as people have consciousness and values that at times lead us to have strong feelings for things that are not happening to us directly, and for people we don't know. To live means to face challenges, losses, and changes. Good therapy leads people to realize that even when you don't wake up in a happy mood and the day may be cloudy, the day is always light and the night is always dark. These are unquestionable facts of life, while what happens in the light and in the dark is not as predictable. It is important to take responsibility and to take care not only of ourselves but others, and the surroundings where we are.

Experiences of traumatic stress are pervasive. As someone who has had opportunities to meet people in different cultural contexts after individual and collective traumatic experiences, it is no longer surprising when someone mentions events and acts that are defined as traumatic, and yet their expression may vary from a loud and hysterical cry to a lowering of the eyes and a deep breath. As therapists we witness and acknowledge the tragic, the disgusting, the experiences of those who tell us their stories and we hope that they will move not towards revenge, mental illness or reenactment, but the very real possibility of post traumatic growth.

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