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Welcome to the first edition of Stress Points for the year. Yes, it has been a long time coming. We welcome a new Stress Points Editor, Rebekah Volgin. Bek joined ASTSS last year and is a PhD student studying with Professor Jane Shakespeare-Finch at Queensland University of Technology (QUT). We are indeed fortunate to have Bek on board. She has bought new energy and enthusiasm to the Management Committee and we look forward to working with you for the years to come. Welcome Bek.

This is also the first Stress Points edition without the guiding hand of Bronwyn Tarrant. As many of you will know, Bronwyn has been with ASTSS for many years and has worked tirelessly in bringing regular updates through StressPoints as well as her blogs and podcasts. Bronwyn is currently taking a break from ASTSS to look after family. Bronwyn we miss you.

We are excited to be bringing Professor Marylene Cloitre to Australia to present a Workshop and Masterclass in Brisbane on 9-10 October, 2015. Professor Cloitre is Associate Director of Research at Paolo Alto VA Health Care Services and Clinical Professor of Psychiatry and Behavioral Sciences at Stanford University. She is the leading authority on the long term effects of childhood and chronic trauma on social and emotional functioning. We are privileged to have such a high calibre academic and clinician coming to Australia.

The workshop and masterclass focusses on treatment approaches that enhance capacity to experience and successfully modulate emotion, function interpersonally, access social support, and develop resilience. The workshop and masterclass are suitable for clinicians wishing to develop a deeper understanding of PTSD and Complex PTSD and in gaining skills in improving affective and interpersonal regulation for individuals and groups. See www.ASTSS.org.au for more details or log into: https://donnazanderandassociates.com.au/ to register. Special prices for ASTSS members.

Arrangements are also underway for our Australasian Conference on Traumatic Stress (ACOTS) biannual conference to be held on the beautiful Gold Coast in 2016 in partnership with Phoenix Australia (formerly ACPMH). Look out for updates as we begin to lock in dates and arrangements.

We will also be having the ASTSS AGM on Friday 9 October at 4pm at The Ship Inn Southbank Brisbane, immediately following Marylene Cloitre's workshop. Please join us for wine and cheese and a brief AGM.

We hope you enjoy the new look StressPoints. Keep your eyes open for future updates as we revamp our website and bring you interesting links and resources over the coming months.

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LETTER FROM THE EDITOR

By Rebekah Volgin

It is with great honour that I present my first edition of the Stress Points newsletter. I am very happy to be part of the ASTSS and look forward to many more editions to come.

I have spent the last few years working and researching in trauma. This has included facilitating a support group for post traumatic stress and working in education at an arts gallery that promotes positive mental health knowledge about mental illness and trauma.

Currently I am completing a PhD on posttraumatic growth. I am very passionate about the field of trauma from both a research and practitioner perspective. Therefore Stress Points will feature articles and interviews from both these perspectives. I also manage the ASTSS website. I am excited to announce that the website is being redeveloped. In particular the way that information is presented will be changed to make it more streamlined and user friendly. I would like to encourage any suggestions or input from members about what they might like to see on the new site. My email address is provided below.

In other news, voting will open in August for the ISTSS Board of Directors. Some of our members are also members of ISTSS and are able to vote in these elections. Assoc. Prof. Meaghan O’Donnell is one of the nominations for President Elect and Prof. Justin Kenardy is nominated for Board Membership. It would be wonderful to support our two leading researchers to continue contributing on the world stage.

I hope you find this edition of Stress Points informative and interesting. The feature article is a interview with Dr Charles Hoge, an expert on combat related PTSD. Dr Hoge discusses a novel treatment for PTSD; Accelerated Resolution Therapy (ART). Dr Hoge was a keynote speaker at last years Australasian Conference on Traumatic Stress.

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I am a social scientist with a PhD and honours degree in Psychology. I am delighted to be the ASTSS President Elect and to work under the guidance of Robyne Le Brocque during her Presidency.

Although I have spent time at the ‘coal face’ of trauma work I am now an academic who works in applied psychology. My area of research is posttraumatic growth which refers to the positive changes a person may find as a result of the struggle they engage in to deal with trauma experience/s.

I spend much of my time working with emergency service populations, designing and evaluating ways in which organisations can proactively promote mental health. I have also worked with an array of other trauma survivors including those who have experienced sexual assault and people who have come to Australia as refugees and asylum seekers.

Over the past few years I have enjoyed being part of the organising and scientific committees for the bi-annual ACOTS conference that ASTSS runs with Phoenix Australia (formally ACPMH) and I am really looking forward to that conference being held on the Gold Coast in 2016. Planning is well underway. As a society I think it is important to bring the latest research and practice ideas to our members and to share with each other so that we may provide the best guidance to each other and to those in need in order to promote mental health within the context of trauma.

Note: Jane will become President of the ASTSS in September 2016 after the Australasian Conference on Traumatic Stress (ACOTS) on the Gold Coast
Interview with Dr Charles Hoge on PTSD Treatments and a Novel Treatment, Accelerated Resolution Therapy

Charles Hoge, M.D., is a internationally-known expert on post-traumatic stress disorder, mild traumatic brain injury and other physiological reactions to war, as well as treatment strategies for war-related conditions. Dr. Hoge’s expertise spans psychiatry, trauma, public health, health policy, and infectious diseases. His articles in The New England Journal of Medicine and The Journal of the American Medical Association are the most frequently cited medical articles concerning the impact of the current wars in Iraq and Afghanistan. He currently works at Walter Reed Army Institute of Research and Walter Reed National Military Medical Center.

This interview will discuss Dr Hoge’s perspective on trauma-focused therapy for PTSD, including recent work with a new psychotherapy, Accelerated Resolution Therapy (ART), being utilized by some clinicians at two large military hospitals in the Washington D.C. area, including Walter Reed National Military Medical Center and Ft. Belvoir Army Community Hospital. ART is a brief exposure based therapy with roots in Eye Movement Desensitization and Reprocessing (EMDR) that has shown promise in treating PTSD symptoms in fewer (2-5) treatment sessions (Kip et al., 2013). The ART intervention consists of four core components: imaginal exposure through visualization, imagery rescripting, in-vitro exposure, and relaxation facilitated with bilateral eye movements (Kip et al., 2014). More information on ART can be found in the reference list at the end of this interview.

Q. How did you come to use Accelerated Resolution Therapy in your practice and why did it appeal to you?

I’ve been trained in Prolonged Exposure (PE) and cognitive processing therapy (CPT), though I found PE and other narrative approaches, like Narrative Exposure Therapy (NET), more useful over the years. Additionally, I have worked with a lot of mental health professionals skilled in EMDR. I’ve been impressed with that approach, and recently trained in EMDR myself.

About a year and a half ago, researchers from University of S. Florida came to Walter Reed to present the findings of the first randomized controlled trial of ART. Although there was very little interest initially among my
colleagues at Walter Reed because this was the first study, the presentation peaked my curiosity. The researchers showed videos of patients who had been treated with ART and there was a veteran there who talked about his own experience with it. This subsequently led to our first training at Fort Belvoir, the partner hospital to Walter Reed; since then, approximately fifteen to twenty clinicians have been trained at Walter Reed and thirty at Fort Belvoir. These clinicians are starting to offer ART as one treatment option to patients and are becoming familiar with how it compares with more established evidence-based treatments. We can’t necessarily consider ART an evidence-based treatment at this point as there is only one RCT, but it is grounded in evidence-based techniques, especially EMDR.

**Q.** Can you describe some of the outcomes you have seen with it?

The technique is very much focused on how trauma is stored in the body, and patients almost always find a sense of relief by the end of each treatment session. Sometimes you can see dramatic efficacy with drops in PCL scores and patients looking much better after just a single session. I’ve had a couple of cases like that, and several where impressive recovery from PTSD has occurred in three or four sessions. However, for the most part those have involved PTSD stemming from single traumas in patients who did not have childhood trauma. When there’s complex trauma, then I’ve also found ART techniques very useful, but the process takes longer.

**Q.** Can you describe the differences between ART and the current standard treatments for combat related PTSD such as prolonged exposure therapy (PE), and eye movement desensitization and reprocessing (EMDR) and do you use ART alongside these evidence-based treatments?

All evidence-based treatments for PTSD, including PE, CPT, trauma-focused Cognitive Behavioural Therapy (CBT), stress inoculation training, and EMDR, involve components of narrative exposure, cognitive restructuring, in-vivo or in-vitro exposure, and relaxation in varying combinations. ART is most similar to EMDR. Both ART and EMDR rely on eye movements (or some form of bilateral stimulation). They both rely on desensitisation through visualisation, asking the person to go back and visualise the trauma or the worst part of the trauma they experienced. EMDR and ART both have an in-vitro exposure component, where you ask the person to visualise a future situation they are anxious about and see themselves being successful. And they both have a body focus, where you attend to the physiological reactions of the body during processing.

Where they differ: the basic structure of the treatment session is very different. The ART desensitization process is much more focused on having a person go back and forth from the image of the traumatic event to their immediate body sensations, and the therapist guides the client’s attention between these two areas of focus. Also during the desensitisation process, there isn’t a specific cognitive focus in ART; ART is more procedural, less free associative than EMDR.

Another area in which they diverge: in ART there is a re-scripting procedure after the desensitization phase where you ask the person to visualise something different in
place of the trauma. This could be visualising something similar but with a different outcome, a completely different event, or another memory one would prefer to hold on to instead (for example, a happy memory of a loved one who passed away rather than the intrusive hospital-related images). Rescripting techniques are used routinely in nightmare CBT for insomnia (Imagery Rehearsal Therapy), and in a CBT protocol for suicide recently published in American Journal of Psychiatry (D. Rudd, et. al). So there is a strong precedent for using re-scripting already. ART extends this to the traumatic experience itself and how the brain stores the information related to this experience. There are also emerging findings from experimental studies of conditioned fear responses by LeDoux and others that support the potential therapeutic application of techniques like this that may specifically target the reconsolidation of traumatic memories.

Another big difference between EMDR and ART is the cognitive focus. In EMDR there is a strong cognitive component where you ask the person to identify their negative cognitions and the positive cognition they want to install instead, including having them rate their level of belief in the positive cognition. The ART procedure is simpler. In ART, we don’t do any of that. The cognitive changes happen naturally, more organically. This is akin to the difference in cognitive restructuring techniques in CPT where this is a primary focus, and PE, where the cognitive shifts happen more naturally over the course of the narrative process. Incidentally, there is a pivotal dismantling study of CPT by Resick, et al. that showed that a simple pure written narrative process is virtually identical in efficacy as the full complex CPT protocol. This also lends support to the fact that negative cognitions do not necessarily need to be primary focus in trauma treatment.

Q. Can ART be used only as a stand-alone treatment or can it be integrated with other evidence-based treatments?

Because ART is not fully evidence-based yet, I think of it as an adjunctive treatment and frequently weave it with other evidence-based techniques. I have also found it useful as a new strategy with patients I’ve worked with over a long time.

Q. Would you say that one of the important elements of ART is that it does tap into the body?

Absolutely. That’s probably the single most important contribution of ART; its very body oriented, honouring the fact that the trauma is stored in the whole body, not just in the mind. One of the nice things about ART is that each session is kind of a stand-alone session; you’re working on one problem, whether it’s a particular trauma the person went through, a current problem they want to work on, or something happening in the future that they’re anxious about.

The body-focus of ART can also be helpful in pinpointing exactly what’s most important to target for treatment. A patient may be experiencing distress but not know exactly what’s going on or what’s triggering the distress, and ART allows you to locate the source of the distress through finding the images connected with the physical sensations (facilitated with the eye-movement process).
Would you recommend ART as a possible intervention for treatment resistant PTSD?

Most of my patients have treatment resistant PTSD, and have been through all sorts of trauma-focused treatments already. ART clearly needs more research; there has only been one RCT. However, in the meantime the clinicians at Fort Belvoir and Walter Reed are getting experience with it, and there is a lot of enthusiasm about the results that they are seeing in patients with treatment-resistant PTSD.

It has an immediate effect that patients appreciate and clinicians also benefit in seeing their patients improve. A lot of times with PE or CBT we end up coming in session after session and the patient doesn’t seem to get much get better or they drop out of care. The drop-out rates are high for all trauma-focused treatments, whereas ART offers the possibility of being able more quickly help people to feel better or shift their thinking about a particular problem that they are having.

Do you make a clinical assessment as to whether someone is suitable for ART? And are there some cases where ART may not be effective for clients with PTSD?

Yes absolutely. You have to ensure you have a full bio-psycho-social understanding and have considered the various options and risk/benefits for treatment. Some patients will not be ready for that kind of treatment or won’t respond to it. If a person has complex trauma or severe dissociation, we have to spend more time resourcing and making sure they have the ability to tolerate strong emotions before proceeding with any trauma work. This may involve mindfulness, breathing, or visualisation of a safe place. You’ll also look carefully at the patient’s motivation for treatment and social supports. The more complex the trauma is and the more physical and mental health co-morbidities that exist (particularly alcohol or substance use disorders) the more difficult treatment will be.

Like all trauma-focused treatment, you have to prepare clients for the possibility that they may experience an increase in distress initially after starting treatment. Both EMDR and ART can produce strong emotions during treatment sessions, and sometimes processing can continue between sessions, so you have to prepare patients about that and make sure that patients are ready for that kind of treatment.

From what we are seeing, however, there seems to be less inter-session distress with ART compared to EMDR because we are usually able to completely resolve one particular problem in each of the sessions. However, there have been no head-to-head comparisons between ART and EMDR, something that is clearly needed. There are also some health conditions where caution is advised, such as a cardiac condition or a history of a seizure disorder.

Recent research points to the use of ART in the treatment of pain that often coincides with PTSD for veterans. What are your experiences treating pain with ART?

Most of my patients have chronic co-morbid pain. The physical and mental health co-morbidities with PTSD are very high, and chronic pain is one of the most common comorbidities we see in combat veterans. The autonomic and neuroendocrine dysregulation
that happens with PTSD affects the whole body. Many of the Soldiers we see have sustained combat injuries, as well as load bearing injuries, and effects from sustained sleep deprivation, in addition to exposure to critical incidents; it’s not uncommon to have chronic generalized health concerns after returning from deployment. It’s also quite striking when doing the trauma work to see how the physical sensations are directly connected with specific traumatic images. I’ve had soldiers, for example, suddenly develop a physical sensation that’s associated with an event, for example sudden light sensitivity because that was the point in the narrative when the blast went off, or throat tightness corresponding to the image of being held down by a perpetrator of rape. The traumatic memories are all manifested in the body. Consequently, after processing the trauma, it’s very common to see pain levels come down, sometimes to a dramatic degree. I have had patients with co morbid fibromyalgia who appear to have resolved their fibromyalgia symptoms after doing several sessions of ART.

Do you think we’ve covered everything? Anything else you’d like to add?

The only thing I’d add is that treatment needs to be individualized. Too often, patients are offered only one or two types of treatment, for example a medication or one type of psychotherapy, without sufficient discussion of the full range of treatment options that might be available. This often leads to dropping out of care. While a lot of additional research is needed before something like ART is considered evidence-based, I think there is role for discussing novel options like ART as well as other complementary and alternative medicine approaches, such as mindfulness, that could be used adjunctively together with more established evidence-based treatments. The most important predictor of treatment efficacy overall is the patients’ willingness to remain in care long enough for treatment to be effective. Offering a range of options may be one way to help foster continued engagement in care.

More information on ART, PTSD treatment, and the comments above can be found from the references below.

References

Hoge CW. Interventions for war-related posttraumatic stress disorder: meeting veterans where they are. JAMA 2011; 306:549-551.


Social Support and Posttraumatic Growth in Support Groups

Rebekah Volgin BA.Hons(Psych)  
PhD Candidate

George Kontis BA.Hons(Psych)  
Provisional Psychologist

As co-facilitators of a structured support group for posttraumatic stress (PTS), we are not strangers to the idea of growth after a traumatic event. We have also witnessed how the support group itself can foster growth. This article will focus on these two themes; how social support, in the form of a PTS support group can lead to positive changes after trauma, and the participants experiences of posttraumatic growth (PTG) in their own lives.

People who have had a traumatic or life threatening event can be left feeling isolated and overwhelmed, and often have physiological and psychological symptoms such as flashbacks, nightmares, intrusive thoughts, heightened anxiety, sleep problems, and more. However, despite the pain and distress, many people also report psychological and spiritual growth, and other positive outcomes from the recovery journey.

‘Posttraumatic growth’ is the product of the cognitive work required to rebuild ones narrative (Triplett et al., 2012). PTG is defined as the experience of positive psychological changes that occur after a trauma and the ensuing struggle to come to terms with the event (Dekel, Mandl & Solomon, 2011). These psychological changes can include the perception of improved interpersonal relationships, enhanced personal strength, new possibilities, spiritual growth and an increased appreciation of life (Tedeschi & Calhoun, 2004). Numerous situational factors can impact on a person’s recovery such as type of trauma (Shakespeare-Finch & Armstrong, 2010) and availability of health services (Stump & Smith, 2008).

In psychological terms, a key factor thought to impact recovery is social support (Tedeschi & Calhoun, 1996). Social support can be defined as assistance, comfort and/or information an individual receives from formal or informal social contacts (Florian, Mikulincer, & Bucholtz, 1995). The construct is further defined along several dimensions, including emotional support (where comfort and caring are expressed) and instrumental support (where resources, services and means of problem solving are provided). Supportive others can create a space for an individual to work through their distress, thus helping them to come to terms with the traumatic event (Prati & Pietrantoni, 2009).

In general, social support has a positive impact on psychological well being (Kafetsios & Sideridis, 2006). Consequently, a lack of social support in stressful situations can lead to increased psychological distress and subsequent PTSD (Mikulincer & Florian, 1997). Social support has been consistently associated with PTSD. Brewin, Andrews & Valentine (2000) found, in their meta-analysis, that a lack of social support was the strongest predictor of PTSD. Additionally, a meta-analysis by Ozer and colleagues (2008) concluded that individuals who reported lower levels of perceived social support after a traumatic event reported higher levels of PTSD. In fact, much of the research suggests that social support counteracts the development of PTSD (Declercq, Vanheule, Markey & Willemsen, 2007). Social
support is also an important factor in development of PTG.

According to PTG theory; the social environment plays an important role in the development and experience of PTG (Tedeschi & Calhoun, 1996). Factors such as social support are believed to moderate the relationship between the distress experienced during and after a traumatic event, and subsequent growth (Splevins et al., 2010). Social support, particularly emotional support, has been associated with PTG (Schroevers et al., 2010).

Social support provided in a group setting may aid the participants in their recovery journey through these processes. The structured support group meets twice monthly in six-session blocks before re-opening for new participants. In our experience this structure has allowed enough time for members to develop a trusting relationship and share openly. Each meeting is generally structured into two parts. The first part of the group is dedicated to the sharing of member's experiences. The nature and content of sharing can vary widely in terms of intensity and content and often, is centered around experienced challenges or growth. The second part consists of an activity, such as co-facilitator led group discussions regarding aspects of trauma or growth and guest presenters, which have included psychologists and art therapists. We posit that support groups which allow for the sharing of experience provides a venue for emotional support, and that combining this with specific activities also allows for a measure of instrumental support.

As consumers of PTG research we felt it pertinent to conduct activities on the construct with group members. Generally this involved a discussion of the research literature as well as a brainstorming exercise to determine whether members themselves have experienced growth as a result of their trauma. In order to communicate the construct effectively, we discuss the general common elements of PTG (Tedeschi & Calhoun, 1996): personal strength, relating to others, new possibilities in life, appreciation of life and spirituality. We have found it helpful to structure our brainstorming exercise along the five domains of PTG, and include member comments below.

In regards to personal strength, members reported their realisations of a number of personal qualities, including patience, wisdom, humility, fallibility, persistence and stubbornness. Recognition of growth when relating to others included appreciating the love of partners, increased empathy, valuing others, clearer or more assertive communication, understanding others with mental illness, being non-judgemental, and the restriction or removal of toxic relationships.

New possibilities were highlighted, including the discovery of new communities and beliefs around the possibility of happiness, self-love, self-efficacy and living authentically. One participant stated “I live my spirituality,” while others recognised increased acceptance for religions, greater present-moment awareness and a “much bigger picture of what life is about.” Lastly, members discussed their increased appreciation for life in terms of their sense of luck, self-appreciation, recognition of how life is too short for unnecessary negative experiences and that “you know how bad it can get so now the everyday seems spectacular.”

Overall as facilitators, we consider ourselves privileged to witness growth in members. In our eyes, members have gained greater self-awareness and wider perspectives, such increased knowledge on how trauma can affect individuals, greater capacity to communicate challenging experiences, and increased awareness of others emotions. We are hopeful that the social support provided in groups such as ours act as a mediating and beneficial force in the growth of individuals experiencing post traumatic stress, and welcome future empirical testing to further this important work.


Diagnosis of PTSD and Complex PTSD: Latest Developments
Skills Training in Affective and Interpersonal Regulation (STAIR) Narrative Therapy
Workshop and Masterclass with Professor Marylene Cloitre

Professor Marylene Cloitre is Associate Director of Research at Paolo Alto VA Health Care Services and Clinical Professor of Psychiatry and Behavioral Sciences at Stanford University. Prof Cloitre is the leading authority on the long term effects of childhood and chronic trauma on social and emotional functioning.

This workshop and masterclass focusses on treatment approaches that enhance an individual’s capacity to experience and successfully modulate emotion, function interpersonally, access social support, and develop resilience.

The workshop and masterclass are suitable for clinicians wishing to develop a deeper understanding of PTSD and Complex PTSD and in gaining skills in improving affective and interpersonal regulation for individuals and groups.

**Workshop** Friday 9 October, 2015
**Masterclass** Saturday 10 October, 2015
The Ship Inn at Southbank
Cnr Stanley and Sidon Street, South Brisbane
(Parking is available for a fee through Southbank Parklands and it is central to public transport)

ASTSS Member: both days $540; 1-day only $300
Non Member: both days $599; 1-day only $330

Day 1: Friday 9 October
- PTSD and Complex PTSD Diagnoses
- Overview of Skills Training in Affective and Interpersonal Regulations (STAIR) for individuals and groups

Day 2: Saturday 10 October
- Skills Training in Affective and Interpersonal Regulation (STAIR) Narrative Therapy

Online secure registration and further information can be found at [www.donnazanderandassociates.com.au](http://www.donnazanderandassociates.com.au) or [www.astss.org.au](http://www.astss.org.au)
NOTICE OF ANNUAL GENERAL MEETING 2015

In accordance with Sections 12 and 14 of the ASTSS Constitution, notice is hereby given that the Australasian Society for Traumatic Stress Studies Annual General Meeting will be conducted on:

Friday 9 October, 2015 at 4.00pm at
The Ship Inn at Southbank
Stanley Street  Sidon Street
South Brisbane QLD 4101

following the ASTSS Workshop with Marylene Cloitre

Sections 12.4 and 12.5 of the Constitution state:
The ordinary business of the Annual General Meeting shall be:
• to confirm the minutes of the last preceding Annual General Meeting and of any General Meeting held since the last meeting;
• to receive from the Committee reports upon the transaction of the Association during the last preceding financial year;
• to receive and consider the statement submitted by the Association in accordance with section 30(3) of the Act; and
• to elect office bearers and Committee members of the Association;

The Annual General Meeting may transact special business of which notice is given in accordance with these rules.

Sections 14.2 and 14.3 state:
• No business other than set out in the notice convening the meeting shall be transacted at the meeting.
• A member desiring to bring any business before a meeting may, not later than one month before the said meeting, give notice of that business in writing to the Secretary, who shall include that business in the notice calling the next General Meeting after the receipt of the notice.

In accordance with Section 14.3, a member wishing to raise business at the AGM must give notice to the Secretary in writing to the address below no later than Friday 11 September, 2015.

Prof Zachary Steel, Secretary, ASTSS
St John of God Chair of Trauma and Mental Health School of Psychiatry, University New South Wales
z.steel@unsw.edu.au
Are you interested in joining the
Australasian Society for Traumatic Stress Studies?

As a member of the ASTSS you will have access to the following:

NETWORKING EVENTS
- Conferences, Speaker Tours, Master Classes,
- Groups - member special interest groups, local member gatherings,
  All of which Attract PD points and member discounts
- Awards, scholarships
- Student representative liation

PUBLICATION
- Stress Points Journal
- Podcast / Vodcast

RESOURCE MATERIAL ACCESS
- Abstracts
- Resources
- Trauma Psychometrics / Instruments

MEMBERSHIP CARD
- Discounts to: Events, Open Leaves Bookshop

In addition to this, the most recent issues of the ejournal, ASTSS Stress Points, are only available to ASTSS members. Trauma specific Podcasts and Vodcasts are loaded regularly throughout the year and are also available only to current ASTSS members. The website provides information on activities within Australasia and internationally, including updates on publications, research projects and topics of interest in the field. Membership provides linkage to people throughout Australasia.

Membership of the Australasian Society for Traumatic Stress Studies (ASTSS) is open to people in the fields of health, welfare, education, emergency services and associated disciplines who have a special interest in the issues of trauma and stress.

**Full Membership** Fee is $75 AUD

**Student Membership** Fee is $50 AUD

Join Today!

[www.astss.org.au](http://www.astss.org.au)