From the President

Paradigm shift to evidence-based practice

The theme of this year’s annual fall conference is “Psychotherapy Outcome in Complex PTSD and Dissociative Disorders: From single case studies to randomized clinical trials.” The importance of this theme to our field and to the future of our field is undeniable. Evidence-based practice (EBP) is the new paradigm for state-of-the-art care in all of medicine, including psychological interventions (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). One prediction is that by the year 2010, evidence-based treatments will be a requirement in all health care systems in the United States (Norcross, Hedges, & Prochaska, 2002). This has enormous implications for those of us who treat complex PTSD and dissociative disorders. I would argue that it is in our best interest to be engaged in the endeavor of determining best practice for the treatment of dissociative disorders and complex PTSD. In this column I will describe EBP and some of the challenges involved in trying to provide evidence for the efficacy of the complex treatments often needed for persons with complex trauma and dissociative disorders. This will be followed by a discussion of some realistic strategies for how we can begin to build evidence for best practice in the treatment of dissociative disorders and complex PTSD.

In order to understand what we can do to influence which treatments are deemed evidence-based or best practice, it is important to first understand how EBP is defined. According to Hunsley, “EBP involves the synthesis of information drawn from systematically collected data, clinical expertise, and patient preferences when considering health care options for patients, and emphasizes the critical importance of informing patients, based on the best available research evidence, about viable options for assessment, prevention, or intervention services” (Hunsley, 2007), p. 48. The good news for us is that there are many different types of evidence. However, not all forms of evidence are considered equally persuasive. Thus, the range of evidence that supports a particular treatment approach will be weighted according to an established hierarchy. The typical hierarchy looks something like the following, which I have ordered from least to most influential: 1) expert opinion, 2) case studies, 3) cohort studies, 4) randomized controlled trials (RCT), 5) critical evaluations and synthesis of multiple research studies, and 6) systematic reviews (i.e. meta-analysis) of RCTs. Thus, while a systematic review of RCTs will be given the most weight, in the absence of highly controlled research, evidence lower down in the hierarchy will have more of an impact.

One byproduct of this paradigm shift has been an increased emphasis on empirically supported treatments (EST). This movement has become so powerful and influential that it has had an impact on training programs, clinical practice, and even what gets funded by insurance companies (Joyce, Wolfaardt, Sribney, & Aylwin, 2007). ESTs are any treatment approaches that are

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deemed to have met a high standard of evidence to support the approach, with the highest standard being the RCT. There is not uniform agreement on what is considered the standard of evidence that must be met but it is not uncommon for it to involve evidence based on at least two or more RCTs.

What defines an RCT, you might be wondering? RCTs test manualized treatment(s) for a specific set of problems in a well-defined population and where recipients of treatment are randomly assigned to treatment conditions. While RCTs meet the highest scientific standards, this type of research design does not lend itself readily to the treatment of complex problems such as dissociative disorders or complex PTSD. For instance, disorders that require intensive, long-term treatment are less amenable to randomization. It is often simply too expensive and too difficult to exercise the necessary controls required for this type of research and there can also be ethical concerns about randomization. Critics of RCTs have taken issue with many of the features of this type of research such as the requirement that all participants in the trial have the same diagnosis with no comorbidity. This is viewed as unrealistic and not representative of the “real world” (Joyce, et al., 2007).

Thus, while RCTs continue to be the gold standard for intervention research, there is a growing recognition of the limitations to this approach. Consequently, there has also been much criticism of ESTs and a move towards the broader concept of EBP which allows for a more extensive range of evidence to support a given treatment approach. An example of this shift is that the American Psychological Association has moved away from EST and now embraces EBP. This is a welcome development and particularly important for our field.

Given the EBP culture in which we now find ourselves, it is vitally important that we engage in gathering scientific evidence to support the work that we do. You might be thinking that the populations we work with are so difficult that it is unlikely that researchers will be able to conduct the necessary research and so we can comfortably rely on expert opinion and case studies. However, I am not so sure this is true. There are a number of sources which provide reports on treatments that are empirically supported, including the Cochrane Collaboration and the Campbell Collaboration. One report from the Campbell Collaboration is “Cognitive-behavioural interventions for children who have been sexually abused” (Macdonald, Higgins, & Ramchandani, 2006). This review concluded that cognitive-behavioral therapy had support as a valid treatment for children who were sexually abused. Depending on your orientation, you may or may not find this reassuring. However, my point is that evidence is accruing regarding the populations that we treat and it is vitally important that clinicians and researchers within our clinical and research community engage in this effort if we want to have our knowledge and beliefs about best practice both validated and disseminated.

Last year, past-president Eli Somer devoted his editorial in the Journal of Trauma and Dissociation to encouraging the use of a single case study (SCS) approach for investigating treatment outcome for dissociative disorders (Somer, 2006). He argued that an SCS approach would enable us to determine what works in treatment for dissociative disorders as well as identifying where we are uncertain or have made mistakes. Ideally, the clinician researcher conducting an SCS would systematically analyze the process of psychotherapy and link the process of the treatment to objective ratings of outcome. The accumulation of a series of SCS reports would provide higher order evidence on appropriate treatment. If this sounds daunting to the clinician nonresearcher, careful notes following each session that track both the client’s participation in the session along with the therapist’s interventions, in conjunction with notes tracking symptoms and other complaints, can provide the evidence necessary to make a contribution to the field. This is especially true given the paucity of evidence for the treatment of dissociative disorders and even complex PTSD. To all our clinicians, I give you a special plea to write up your cases and submit them to JTD for publication.

Along with SCS, I suggest that a higher level of psychotherapy research is also possible within our field. Here, I refer to empirical investigations of naturalistic treatments that do not utilize randomization or other controls. This research involves providing treatment to a well-defined population (e.g., meets criteria for a dissociative disorder), utilizing a pre/post design and, ideally, employing process measures. The aim would be to relate the process of treatment to outcome. Of course, the challenge is to be able to accurately describe the treatment used, as well as utilizing sensitive pre/post and process measures. However, assuming this is done well, this type of research can provide higher order evidence on what works in our treatment approaches.

Consider the following study that investigated naturalistic treatments for panic disorder (Ablon, Levy, & Katzenstein, 2006). Although this is not a study of either complex PTSD or dissociative disorders, it provides an example of naturalistic research and I suggest this type of research is viable with the populations we serve. This study examined 17 cases that were treated for panic disorder by psychodynamic therapists using whatever treatment approach they deemed appropriate for a treatment that lasted an average of 21 months. Patients were given self-report measures to complete pre/post and the therapist rated their patient’s symptomatology, general psychological functioning, defensive styles and object relations also pre/post. An independent rater rated panic symptomatology only. All sessions were audiotaped and rated using the Psychotherapy Process Q-Set (PQS; Jones, 2000), which enabled the researcher to accurately classify the treatments used.

At the end of treatment, the investigators found that patients improved on a range of measures rated by the patients, clinicians as well as the independent raters. Using these three perspectives to assess outcome increases one’s confidence in the validity of their outcome findings. However, the most interesting aspect to this study was what they found when they examined process. Although the therapists all identified themselves as psychodynamic in their approach, the strategies most frequently used were cognitive-be-
ISSTD Component Group News

It is with great pleasure that we announce the addition of two new ISSTD Component Groups – the Paris Clinical Group for the Study of Trauma, PTSD, and Dissociation and the Anchorage Trauma & Dissociation Study Group.

ISSTD Component Group status has been conferred upon the Paris Clinical Group for the Study of Trauma, PTSD, and Dissociation, effective January 4, 2007.

New Web Site Online April 2, 2007

Over the past 6 months, volunteers from ISSTD have been working behind the scenes to create the new ISSTD website. This effort has been spearheaded by two of our past presidents: Eli Somer, Ph.D as Chair of the Website Committee, and Richard A. Chefetz, M.D. as Web Editor, with the assistance of Ava Schlesinger and Teresa Gutsick as our graphic designers. The Website Committee has worked closely with ISSTD Headquarters to design a site that will not only have a whole new look but also increase our online resources and usability.

The original design for this site was unveiled at the 2006 Fall Conference in Los Angeles and since then has gone through many more changes and evolved into a resource that we believe will benefit mental health professionals all over the world. The new site will provide more ways to participate in the organization and to communicate with peers. It will also provide a new online shopping cart with books and products related to all aspects of psychology. We are excited to launch this new site to our members and to the public and we expect it to be officially released on April 2, 2007. Look for a letter in your mailboxes from Headquarters with your Members Only logon information. You will have the opportunity to take a look at what we have come up with, share your thoughts, and update your information instantly.

Trauma and Dissociation Israel

Trauma and dissociation Israel (TDIL, www.tdil.org) has completed its registration with the Israeli authorities as a non-profit organization, and currently has 67 members. This one-year-old component group held 3 meetings in 2006, at which lectures were given by TDIL volunteers, and a 2-day conference featuring Rich Chefetz and key Israeli dissociation scholars. Our education activities focused on topics such as Counter Transference Issues, Art Therapy Perspectives on Treatment with Dissociative Disorders, and Dissociation during the Holocaust. We have also formed a new Israeli study group that began meeting in Northern Israel in 2007 under the title: Northern Israel Peer Group on Trauma and Dissociation. TDIL’s activities attract a growing interest among Israeli professionals; many have joined our mailing list and show up for our educational activities.

TDIL members enjoy a news service on issues of interest, provided by one of our volunteers.

Our chair for 2007 is Liora Somer, MA. Under her leadership we hope to launch our new website, to have a successful 2-day educational meeting, to launch another DDPTP course, and to further increase our membership.

Talma Cohen, Ph.D., TDIL Foreign Relations Coordinator
talmacohen@yahoo.com

The group is located in Paris, France, and currently consists of 3 members, all of whom are also ISSTD members. You may join us, if you’d like, in welcoming the Paris Clinical Group for the Study of Trauma, PTSD, and Dissociation, or obtaining additional information about the group, by contacting ISSTD member Stephanie O. Kleindorfer, PsyD at:
drk@capaconsult.com.

The Anchorage Trauma & Dissociation Study Group has been conferred Component Group status effective February 27, 2007. The group is located in Anchorage, Alaska and, at the time of application, consisted of 19 members, 2 of whom also belong to ISSTD. Information about the Anchorage Trauma & Dissociation Study Group may be obtained by contacting ISSTD member Katie Fallin, LPA, CTS at: fallin@alaska.net.

ISSTD would like to welcome both of these groups to our roster of Component Groups and extend our best wishes for a successful experience. Any interested ISSTD members and colleagues can find information about establishing a Component Group in your area by visiting the ISSTD website, Component Groups page. Check out the online ISSTD Component Society/Study Groups Guide, or contact the Component Group Committee chair, Dennis S. Pilon, LMSW, ACSW, BCD, at: DSPilonTRC@aol.com.

ISSTD Professional Development Seminars

We are pleased to remind you of the remaining schedule for the 2007 ISSTD Professional Development Seminars.

April 20, 2007 – Baltimore, MD
May 18, 2007 – New York, NY

John Briere, PhD
presenting on:
Advances in the Integrated Treatment of Complex Trauma

REGISTRATION NOW OPEN!
http://www.traumarecoverycenter.com/seminars.html

Watch your ISSTD News and the ISSTD website for further details and future developments. If you or your Component Group/organization would like to see an ISSTD Professional Development Seminar in your area, and you have suggestions for facilities and/or speakers, please submit your ideas to the committee. Further information can be obtained from the ISSTD Professional Development Seminars Committee by contacting:
Dennis S. Pilon, LMSW, ACSW, BCD at: DSPilonTRC@aol.com.
Critical Issues

Dissociation: Definitions, Development, and Challenges

Anne P. DePrince
University of Denver
Lisa DeMarni Cromer
University of Oregon

This Critical Issues Column is an extension of DePrince and Cromer’s editorial in the November 2006 issue of the Journal of Trauma and Dissociation (JTD), a special issue dedicated to papers exploring the definition, development, and cognitive correlates of dissociation. We take the opportunity here to highlight some of the papers from this volume as well as to place those papers in the larger context of critical issues for promoting the science of dissociation.

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e stand on the shoulders of clinical and research giants whose work evidenced the existence of dissociative phenomena. Early endeavors to document dissociative phenomena were primarily based on case studies and philosophical musings (see Rieber, 2002 for historical review). Remarkably, many of the ideas of the early theorists who grappled with dissociative phenomena (such as William James, Pierre Janet, G. E. Muller, and Morton Prince) are quite relevant today. For example, Janet talked about divided consciousness, Muller hypothesized inhibition as being related to dissociation, and Morton Prince postulated that more than one explanatory principle would be needed to account for the various facets of dissociation (Rieber, 2002).

From the vantage point on these giants’ shoulders, we see at least 4 major issues that scientific approaches to dissociation cannot address. These issues are ever-informed by the historical work of theorists in the context of recent discoveries and exciting new methods. We describe 4 major issues here and call for additional empirical research in these domains.

Issue 1: Dissociation happens…but what is it (and what is it not)?

The field has entered an important time of re-evaluating just how we define and conceptualize dissociation. Looking back over the last 20 years of increasing research and clinical interest in dissociation, frameworks for organizing dissociative phenomena have developed, at times, in an ad hoc or piecemeal manner. The scope and specificity of the term dissociation has been affected by problems of both over- and under-inclusiveness (see van der Hart, Nijenhuis, Steele, & Brown, 2004). That is, dissociation has at times been defined so broadly that seemingly any alteration in consciousness is included, making the construct too general to be of use. Alternatively, flashbacks and other re-experiencing symptoms have at times failed to be included among dissociative phenomena. A host of engaging and important articles on the very nature and definition of the phenomena have emerged in the past few years (e.g., Brown, 2006; Dorahy, 2006; Holmes et al., 2005; van der Hart et al., 2004; Waller, Putnam, & Carlson, 1996).

Definitional issues are of central importance to both theory-building and empirical investigations. As the field grows, delineating and clarifying definitional issues, such as whether dissociation is premised to be a state or trait, a continuum or a taxon, an outcome or a mechanism (DePrince & Freyd, in press), is of critical importance for several reasons. Theory building, assessment, data collection, and data interpretation all inherently depend on answers to each of those questions. Furthermore, issues of construct validity (i.e., are we measuring the construct, the whole construct and nothing but the construct) affect all stages of the research process. For example, to the extent that we include relatively more common forms of alterations in consciousness (e.g., absorption) and then find relationships with other variables of interest, we cannot be sure whether the relationships are due to the more common or extreme dimensions of dissociation. Then, we use findings that blend potentially different phenomenon (e.g., common alterations in consciousness and more severe dissociation) to infer something about the phenomenon itself. Thus, for the field of dissociation to continue to advance, definitions of the construct need to be directly addressed.

Clarifying definitional issues is at the heart of theory development. To the extent that the field is actively engaged in work to identify both the etiology and function of dissociation, what we count as dissociation in any given study (or any given sample) directly influences theory-building. For example, studies that measure dissociation differently may come to different conclusions about the function of dissociation. Therefore, only when we have a well-defined construct can we engage in the extraordinarily important work of testing and reconciling competing theories regarding the function, etiology, and underlying mechanisms of dissociation. Thus, from early research design efforts up through data interpretation, definitional issues are a core concern.

Issue 2: What are the mechanisms by which dissociation develops?

We know strikingly little about how dissociation – whether typical or pathological, on a continuum or taxon – develops. Several theories provide roadmaps for how dissociation might develop, such as Putnam’s (1997) Discrete Behavioral States Model or Liotti’s (2006) views of the role of attachment. Much theory converges on the idea that developmental processes are critical to dissociation. Indeed, the roles of parenting and early exposure to violence are highlighted in both of the approaches mentioned above. Empirical investigations, such as Chu and DePrince’s (2006) study of the relationship between child dissociation in the context of parent factors (including parent dissociation, parent trauma exposure,
Theoretical and empirical attention is necessary to distill and extend this literature. Recent years (e.g., Becker-Blease et al., 2004) have seen more developmentally-minded theories point to a genetic contribution to dissociation, at least to normative dissociation (e.g., Brown, 2006). In the context of more developmentally-minded theories and a growing body of research with children, we have new opportunities to engage critically important questions about how dissociation develops. In the future, we hope to see longitudinal studies address questions about the structure (e.g., taxon, detachment; for related issues, see Brown, 2006); and development of dissociation.

**Issue 3: What is the function?**

The motivation (conscious or unconscious) or function of dissociation has often been confused with the processes by which dissociation may develop. Indeed, dissociative experiences may occur independent of a particular function. For example, a particular cognitive style, such as high distractibility, or daydreaming, might present a risk factor for developing dissociation. Over time, the individual begins to use this ability, either accidentally or intentionally, for coping with day-to-day life perturbations as well as for trauma-related emotions and information (see Butler, 2006). These attentional styles or abilities might place children at risk for dissociation while also providing them with ways to cope with chronic violence. In such a case, the initial dissociative experiences are not necessarily tied to a defensive or adaptive function at all; in fact, a third variable (distractibility in this example) predicts both the coping and dissociation. As views about both the function and etiology of dissociation have expanded in recent years (e.g., Dorahy, 2006), additional theoretical and empirical attention is necessary to distil and extend this literature. Thus, we look forward to future research that carefully considers and attempts to disentangle the complex relations between etiology and function.

**Issue 4: What are the consequences?**

As the concept of dissociation has gained traction in mainstream psychology and psychiatry in recent years, empirical investigations have enhanced our understanding of the complexity of dissociative phenomena and the consequences of these experiences. Against the backdrop of developing tools to aid in the differential diagnosis and burgeoning exploration into cognitive neuroscience of trauma, investigations into the cognitive correlates of dissociation are a rapidly evolving frontier. Cognitive research and data interpretation are (as all research is) influenced by the paradigm of the investigator. Thus, approaches to examining the cognitive correlates of dissociation tie back to the experimenters’ views of the etiology and development of dissociation. For instance, to the extent that dissociative experiences are viewed as pathological in nature, investigations are more likely to focus on deficit-based outcomes. Likewise, to the extent that dissociation is viewed as protective and adaptive, investigations will be geared towards identifying strengths correlated with dissociation. Dissociation may be viewed as a continuum from normative to pathological (Butler, 2004, 2006). A dialectical view – that dissociation may be both adaptive and harmful (see DePrince & Freyd, in press) – acknowledges both positive and negative correlates of dissociation. As researchers with diverse views about etiology and function of dissociation have ventured into cognitive research, both expected and unexpected findings have emerged. The studies in this volume highlight some interesting, and perhaps surprising, relationships between dissociation (or dissociative styles) and seemingly adaptive aspects of the cognitive flexibility.

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**At the crossroad of current issues.**

As scientists, we will continue to grapple with the various facets, functions, and correlates of dissociation. Definitional issues will necessarily influence how etiology and function are conceptualized, as well as which correlates we will examine. These inter-related issues will be influenced by our theoretical perspectives as we approach the research with a premise that dissociation is adaptive or maladaptive, pathological or normative. For example, if dissociation is defined as pathological, views of the function and etiology of dissociative experiences will be linked to that perspective, providing explanations for a problem. Similarly, how one views function and etiology will act as a compass for broader theorizing. Further, the framework used to conceptualize etiology acts as a testament for understanding the role of development and dissociation (and vice versa). To the extent that theorists believe dissociation serves a protective function for children in violent environments, theories about the etiology of symptoms will be tied to those environments. In turn, views of both etiology and function necessarily inform intervention theory and practice.

**Addressing these Issues.**

The November 2006 special issue of the JTD addresses several of the issues raised in this column, including: definitions, etiology, function, and cognitive correlates. Volume contributors include international experts on dissociation, cognition, development, and clinical science. This volume offers a compilation of theory and empirical research in a series of chapters that synthesize existing literature with advanced study. The contributors also pose innovative questions about correlates of dissociation. Across articles the contributors offer rich discussions of previous research to inform new viewpoints. This volume is poised to galvanize discussion about models of dissociation, particularly innovative views of dissociation, cognition and development. The November 2006 JTD issue is by no means an exhaustive review of the exciting breadth and depth reflected in the dissociation literature; however, we hope these contributions will galvanize interest and discussion in pushing explorations of dissociation forward.

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Most of us think of a child's hope as something effusive, ebullient, resolute and absolute. But void?

I had a run-in with hope last year when three 4th graders on my caseload in a struggling inner-city public school brought in an assignment they had to complete for the class's bulletin board. The children were instructed to write an essay about: "What I hope the world will be like when I am grown." None in the ten-year-old trio had any clue how to approach the task—all had serious language and writing issues and one couldn't yet read, let alone write expressively. Noting their distress, I offered to work on the class assignment with the boys during our speech-and-language session. However, before helping them verbalize any coherent narrative response, I needed to make sure they comprehended the words involved.

“What does ‘grown’ mean?” I asked. They didn't know. I explained. That was easy enough to teach.

Then I asked, "What does ‘hope’ mean?” Blank faces.

"Is hope a good thing or a bad thing?” Blank faces.

“Well, what do you think?” I prompted, undeterred. “If I say, ‘I hope it will be nice outside tomorrow so that I can go to the park’, what do you think I mean?”

Blank again.

“Let’s think about it together. Is hope something that makes people feel good or feel bad?”

Silence. The kids looked around the room as if the walls suddenly sprouted X-boxes. Then a brave soul took a chance, "um...Miss. Y., maybe...a bad thing?”

"A bad thing? Okay, how come?”

“Um...I don’t know...I just thinking it a bad feeling thing...”

There was a pregnant pause, and a moment later another child chimed in, “Yeah, it bad because it is like, everything is only being mess up already, so when I grow up it will be even more mess up...”

Nods galore.

This was more than a language issue, beyond the gaping canyons of missing concepts and speech difficulties. This was a reality communicated. All three boys (and many other children I see; as well as, I'd guess, many of the dissociative adults who've had such hope-deprived upbringings) had very little experience with any hope that wasn't completely drowned in disappointment and failed promises. They also had little to hope for and were constantly flagged for their failures rather than their successes. To outside eyes they were failing in a failing school in a failing neighborhood in failing families. Their life experiences (and all too often those of their parents) gave them little reason to imagine that things could be different. And so they found it difficult to conjure images in their minds of anything that would not be bleak, disheartening, and half-baked.

How do we define “hope” to someone who doesn’t know what it is?

For me, it felt a bit like teaching a blind person about colors—so tangible to those of us who can see, yet so nakedly absent to those born sans sight. I can appreciate how hard it must be to teach the concept to older adults who’ve known so many years of hopelessness. It is definitely hard enough to teach hope to children who are still in the midst of hopeless—or almost hopeless—situations.

To drive the concept home for my three Musketeers, I decided to have a drawing competition and enlisted a friend to be a judge. The children were allowed to hope that they would win, because if they did (which all three just happened to do, for various “artistic skills”) they'd get a drawing set, a big deal for children who rarely have an extra pencil let alone paper and paints. We hoped for good weather so that they'd get to pass 15 minutes of their lunch time in the tiny paved school courtyard. We hoped that the microwave-cookies we were improvising in the Speech Room would come out reasonably okay (they didn't, and we all laughed, and I pulled out store-bought cookies I’d brought anticipating that we might need backup). We talked about how hope doesn’t always mean we'll get what we’ve hoped for but is still something that makes us feel very good inside while we do. We hoped and hoped, and it took some weeks, but I think maybe a seed of the concept was planted.

“Those kids were the first children to be taught hope. To drive the concept home for my three Musketeers, I decided to have a drawing competition and enlisted a friend to be a judge. The children were allowed to hope that they would win, because if they did (which all three just happened to do, for various “artistic skills”) they'd get a drawing set, a big deal for children who rarely have an extra pencil let alone paper and paints. We hoped for good weather so they'd get to pass 15 minutes of their lunch time in the tiny paved school courtyard. We hoped that the microwave-cookies we were improvising in the Speech Room would come out reasonably okay (they didn't, and we all laughed, and I pulled out store-bought cookies I’d brought anticipating that we might need backup). We talked about how hope doesn’t always mean we’ll get what we’ve hoped for but is still something that makes us feel very good inside while we do. We hoped and hoped, and it took some weeks, but I think maybe a seed of the concept was planted.

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"Is the Tooth Fairy real?" The fair-haired first-grader's eyes were piercing with challenge. His finger touched a fresh one-tooth-gap; his first.

"What do you think?" I returned a question, not sure where this was going.

"I think she's only pretend." He looked crushed.

"She is?" I feigned shock.

"Yeah! Because it's too many kids, right?" Full lilt and faith in things unseen restored. "Maybe she asked them to help her and gave them money for under my pillow because she had to go all the way somewhere far, like to New Jersey..."

If Tooth Fairies need help reaching their goals, how much more do we who lack wings and fairy-dust? The Development Committee is dedicated to seeing ISSTD and the study of the dissociative disorders rise to greater respect and understanding in the clinical world. However, even Tooth Fairy business comes down to dollars and cents. Similarly, the way ISSTD will best be able to command that respect is through funding that will enable greater visibility and broader educational impact, and by attracting more members of the highest caliber. For that, we need your help. We need you to be the Tooth Fairy that will enable us to keep the promise of magic—under-the-pillows-of-healing alive. The money donated to the Development Campaign is earmarked for raising awareness and support for education, assessment, treatment, and research on the dissociative disorders. It is the Development Campaign's Mission Statement. It is what we're here for.

Having entered the fourth year of our campaign, we're continuing to move toward reaching our five-year target of $250,000 (see graph for monies given and pledged to date). With that money we're hoping to make magic—magic to help you work better with your clients, magic to make the all-too-often invisible realities of trauma and dissociation visibly indisputable. If you haven't yet become a part of our effort, please do! Like a quarter under a child's pillow—every little bit is significant. If you've already joined the campaign, you know the glittery glow of things-important in your heart... We thank you. Most importantly, those who look to you—to all of us—to help restore the sparkle in their eyes thank you. Remember, you can make a difference. We can't do it without you!
What your donations accomplish

Child Protective Services Video Project: Fran Waters’ pioneering project to bring more awareness of dissociative symptoms in children to first-line responders and professionals is moving in leaps and bounds. Your generous Development contributions enabled ISSTD and Cavalcade Productions to film a three-part DVD series most recently at the International San Diego Conference on Family Maltreatment in January. The series has entered its editing stage: the first part will address Neurobiology of Trauma and the Global Effects of Chronic Traumatic Stress on Children, the second will cover the Assessment and Forensic Issues, and a third will cover prosecution. Team contributors to the video series were recognized professionals in the field of childhood trauma and forensic evaluations of children: lawyers, psychologists, social workers, psychiatrists, and protective service workers. The series will be available in DVD and VHS formats, and will no doubt become a priceless contribution to children’s safety and to early identification. Marketing is anticipated in the spring (subtitles in non-English will be possible for interested countries). Over the next year, Fran will conduct a series of workshops at major child-trauma conferences utilizing this DVD, to encourage awareness and understanding of children’s dissociative mechanisms in the forensic environment, and to market this training video to forensic evaluators and protective service workers. Kudos to Fran for spearheading this immensely important project and maneuvering it skillfully through its early hurdles!

Dissociative Disorders Interview Videotape Project: This important professional tool continues to shape up. Look for news about Dr. Richard Loewenstein’s Office Mental Status Interview for Complex Dissociative Symptoms in the coming months. The DC will be supporting the distribution of this video.

2nd DSM-V Research Planning Conference: Stay tuned for news about this significant and complicated effort to ‘save’ the Dissociative Disorders from denial and allocate them a befitting place so that those suffering from them are better understood, seen, and heard.

David Caul Research Grants: $5,000 in award funds are allocated annually for supporting post-graduate students researching dissociative disorders. The DC proudly sponsors these essential building blocks to our field’s future.

Don’t forget…yearly membership dues go to for operating expenses; but monies for the DC are exclusively for funding projects designated to making the dreams of today the reality of tomorrow. Please make a secure donation online at: www.ISSTD-D.org or send a check for the Development Campaign. Fifty cents or fifty thousand dollars—it all helps.

We at the DC are committed to building a future of healing. Please email us with your ideas, comments, and questions.

Magical giving: Support ISSTD as you shop!
iGive: The more you shop, the more you give (yes, you get to keep the shopping; and no, it doesn’t cost you a penny more!)

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Thank you!

Making schools into life-rafts for traumatized children: 
A how-to book for educators, therapists, parents, and policy makers.

By Na’ama Yehuda, MSC SLP TSHH
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Written by a team of professionals in education, mental health, and law, this report/manual outlines how schools can—and should—deal with traumatized children. With clear language light on the jargon, it represents a trail-blazing effort to systematically help the hundreds of thousands of traumatized children in the educational system by educating their educators and putting plans in place that can help children learn. This trauma-sensitive policy is currently implemented as a district-wide policy in Framingham, MA.

The book is comprised of three sections: in part one, the impact of trauma on children’s development, behavior, and subsequent availability to learning is described (as well as misdiagnoses, particularly ADHD); in part two, the flexible framework for making schools trauma-sensitive is detailed; and part three lists policy recommendations. An appendix contains the “Safe and Supportive Schools Legislation,” passed in Massachusetts in 2004 to help schools address the needs of traumatized children via grants for innovative approaches to alternative education for older at-risk children, as well as regular education interventions that address the educational and psychosocial needs of traumatized children.

The Flexible Framework plan for making schools trauma-sensitive is inspiring. It depicts a thorough and thoughtful effort to allow traumatized children the help they are worthy of receiving. Aspects of the policy include: evaluating and reorganizing school-wide infrastructure and culture; trauma-training staff; linking up with area mental health professionals versed in trauma; providing trauma-sensitive academic instruction; encouraging non-academic strategies for attachment developing; and reconsidering school policies, procedures, and protocols. It is an in-depth overhaul of the trauma-blind schools of today. Because of its thoroughness, the framework has the potential to be daunting to schools where assistance on the scale described may not be available. Implementation of the policy is not likely without legal, State, and district support; especially in school districts that are already understaffed and under-budgeted.

That being said, there is plenty of information schools can find helpful. Educating teachers about trauma and applying even some of the recommended changes can mean providing children with at least a benign—if not optimally supportive—school experience. Helping Traumatized Children Learn can launch that dialogue.

A potential weakness of the book is that while dissociation is noted as one way children might cope with trauma, the authors seem to shy away from mentioning dissociative disorders (or dissociative symptoms) as outright by-products of trauma. The one example of dissociation described is under the discussion of withdrawal: “Some traumatized children disconnect themselves from the present by dissociating, or ‘going away’ in their minds; they may not be aware that they have ‘left’ the classroom and missed large amounts of information. Dissociation may be hard for a teacher to recognize unless it is extreme.” (p. 37)

Given the book’s minute and careful attention to listing numerous symptoms and behaviors, the lack of a ‘dissociation’ subtitle seems even more pronounced, especially with many incidences of what can be clearly defined as dissociation described in the book. For example, as part of “how processing problems…affect learning” the authors quote a teen: “I could see the math teacher’s mouth moving…but couldn’t hear a thing. It was as if I were in a soundless chamber. She was smiling and clearly talking. I just couldn’t process a word of it…” (p. 24). In that sense, the book misses an opportunity to educate about dissociation as a reaction that frequently underlines post-traumatic coping.

Overall, Helping Traumatized Children Learn is a useful and timely report brimming with practical steps for educators to take in order to recognize signs of trauma and help children affected by it. An important resource for any therapist who works with school-age children, it would do well to serve as a catalyst for Departments of Education everywhere for making schools safe and healing places where children can be available play, learn, and grow.

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Psychotherapy Outcome in Complex PTSD and Dissociative Disorders
From Single Case Studies to Randomized Clinical Trials
Brantd, J., & Van Gorp, W. G. (2006). Functional (“psychogenic”) amnesia. Seminars in Neurology, 26(3), 331-340. Patients who present with severely impaired memory functioning without a discernable neurological cause typically have experienced one or more severely stressful life events. These patients, who are described as having “psychogenic” or “dissociative” amnesia, typically differ from patients with the neurologic amnestic syndrome in that memory for their personal life histories is much more severely affected than is their ability to learn and retain new information; that is, they have isolated retrograde amnesia. Recent cognitive and brain imaging research has begun to reveal some of the cerebral mechanisms underlying functional amnesia, but this disorder remains best conceptualized as a relatively rare form of illness-simulating behavior rather than a disease. Neuropsychological assessment is often useful in revealing the circumscribed nature of the patient’s performance deficits, the spared functions that can be brought to bear in rehabilitation, and the emotional disorders requiring psychiatric treatment. Controlled treatment trials are nonexistent, but case reports suggest that supportive psychotherapy, systematic relaxation training, hypnosis, and sedative/anxiolytic medications are useful in facilitating recovery. These treatments are often combined with a psychoeducational approach that essentially reteaches the patient his or her life story.

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Brauchle, G. (2006). [Persistent dissociation as predictor of posttraumatic stress disorder in psychosocial disaster workers]. Psychotherapy, Psychosomatik, 56(8), 342-346. BACKGROUND: The author prospectively examined the power of persistent dissociation in predicting acute and chronic posttraumatic stress disorder symptoms (PTSD) in psychologists, psychotherapists, crisis intervention teams and clergymen after a disaster. METHODS: 135 psychosocial disaster workers were assessed (6 weeks and 6 months after the catastrophe) with the Acute Stress Disorder Scale (ASDS), the Posttraumatic Stress Diagnostic Scale (PDS) and the German short version of the Dissociative Experience Scale (FDS-20). Correlational analysis and a hierarchical multiple regression analysis were conducted. RESULTS: Persistent dissociation and acute stress symptoms were correlated with later acute and chronic PTSD diagnosis. Together, persistent dissociation and acute stress symptoms accounted for 74 % (m)/36 % (w) of the acute and 58 % (m)/44 % (w) of the variance in PTSD symptoms. CONCLUSIONS: The results support that persistent dissociation is a main predictor of acute and chronic posttraumatic stress symptoms in disaster workers.

Reprints: Gernot Brauchle, Institut für Hygiene, Mikrobiologie und Sozialmedizin, Medizinische Universität Innsbruck, Christoph-Probst-Platz, Innsbruck 52, 6020 Innsbruck, Austria. Email: Gernot.Brauchle@uibk.ac.at

Elzinga, B. M., Ardon, A. M., Heijnis, M. K., De Ruiter, M. B., Van Dyck, R., & Veltman, D. J. (2007). Neural correlates of enhanced working-memory performance in dissociative disorder: a functional MRI study. Psychological Medicine, 37(2), 235-245. Background. Memory functioning has been highlighted as a central issue in pathological dissociation. In non-pathological dissociation, evidence for enhanced working memory has been found, together with greater task-load related activity. So far, no imaging studies have investigated working memory in dissociative patients. Method. To assess working memory in dissociative patients functional magnetic resonance imaging was used during performance of a parametric, verbal working-memory task in patients with a dissociative disorder (n=16) and healthy controls (n=16). Results. Imaging data showed that both groups activated brain...
regions typically involved in working memory, i.e. anterior, dorsolateral and ventrolateral prefrontal cortex (PFC), and parietal cortex. Dissociative patients showed more activation in these areas, particularly in the left anterior PFC, dorsolateral PFC and parietal cortex. In line with these findings, patients made fewer errors with increasing task load compared to controls, despite the fact that they felt more anxious and less concentrated during task performance. Conclusions. These results extend findings in non-pathological high dissociative individuals, suggesting that trait dissociation is associated with enhanced working-memory capacities. This may distinguish dissociative patients from patients with post-traumatic stress disorder, who are generally characterized by impaired working memory. 

Reprints: Bernet Elzinga, Section of Clinical and Health Psychology, University of Leiden, Postbus 9555, 2300 RB Leiden, Wassenaarweg 52, The Netherlands. Email: elzinga@fsw.leidenuniv.nl

Endo, T., Sugiyama, T., & Someya, T. (2006). Attention-deficit/hyperactivity disorder and dissociative disorder among abused children. Psychiatry and Clinical Neurosciences, 60(4), 434-438. The aim of this study was to investigate the psychiatric problems and characteristics among children of child abuse (CA). Specifically, the authors investigated whether attention-deficit/hyperactivity disorder (ADHD) symptoms were exhibited before or after CA. A total of 39 abused child inpatients who were treated at Aichi Children’s Health and Medical Center, Aichi, Japan, (mean age, 10.7 +/- 2.6; mean IQ scores, 84.1 +/- 19.3) were included in the study. The most frequent diagnosis was dissociative disorder in 59% of abused subjects. ADHD was diagnosed in 18% of abused subjects, and 71% of ADHD children had comorbid dissociative disorder. A total of 67% of all CA subjects fulfilled the ADHD criteria A according to DSM-IV-TR, however, only 27% of those fulfilled the criteria before CA. The subjects of dissociative disorder fulfilled ADHD criteria A more frequently than those of non-dissociative disorder (P = 0.013), and this result led to an increase in the frequency of the apparent ADHD. The rate of ADHD-suspected parents in the subjects who fulfilled ADHD criteria A after CA was significantly lower than those who fulfilled it before CA (P = 0.005). While it is difficult to distinguish ADHD from dissociative disorder, abused children may have increased apparent ADHD due to dissociative disorder. Further studies should be conducted in order to explore the distinct biological differences between ADHD before CA and the subjects who fulfilled ADHD criteria A after CA.

Reprints: Tarou Endo, Department of Psychiatry, Niigata University Graduate School of Medical and Dental Science, Niigata, Japan. Email: tarou@med.niigata-u.ac.jp

Frewen, P. A., & Lanius, R. A. (2006). Toward a psychobiology of posttraumatic self-dysregulation: reexperiencing, hyperarousal, dissociation, and emotional numbing. Annals of the New York Academy of Sciences, 1071, 110-124. In this article we propose a psychobiological model that construes PTSD fundamentally as a disorder of affect arousal regulation. Neuroimaging studies of emotion regulation in psychologically healthy populations are initially reviewed as a framework for interpreting the results of previously published investigations of the neural correlates of PTSD reexperiencing and dissociation. We then apply the emotion regulation framework toward understanding other perturbed affective states in PTSD. We conclude by discussing the clinical significance of this framework for psychological assessment and treatment of posttrauma psychopathology.

Reprints: Ruth Lanius, London Health Sciences Centre, 339 Windermere Road, PO Box 5339, London, Ontario, N6A 5A5, Canada. Email: ruth.lanius@lhsc.on.ca

Goffinet, S. (2005). Le Satanisme : du folklore à l’abus rituel. Neurone, 10(7), 215-220. (Dutch translation: “Satanisme: van folklore tot ritueel misbruik.” English translation: “Satanism: From folklore to ritual abuse”). The phenomenon of satanic groups remains controversial, especially in Europe. Although some adolescents are clearly suffering from different forms of maltreatment by groups, the broad spectrum of this phenomenon extends from mere eccentricity to true ritual abuse. The kind of abuse will determine the appropriate treatment choice. Different kinds of interactions between perpetrator and victim provoke different types of symptoms, including dissociative disorders.

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Goffinet, S. (2006a). Le Pardon dans la psychothérapie des adolescentes abusées dans leur enfance. Revue Francophone du Stress et du Trauma, 6(3), 155-162. (English translation: “The role of forgiveness in the psychotherapy of adolescent girls abused in childhood”). Forgiveness is an issue that arises in the psychoanalytic psychotherapy of adolescent girls psychologically traumatized in childhood. Four different kinds of forgiveness are identified: Forgiveness by others Forgiveness of oneself God’s forgiveness Forgiveness through a third person

The psychotherapist must deal with essential questions of forgiveness arising out of the entanglement of moral, judicial and clinical judgments.

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Goffinet, S. (2006b). Les adolescentes automutilantes à l’hôpital. Cahiers critiques de thérapie familiale et de pratiques de réseau, 36, 155-167. (English translation: “Self-mutilating adolescent girls in the hospital”). Most female adolescent inpatients have been traumatized during childhood and have dissociative symptoms. When in an altered ego state, self-injurious behavior may occur. Disappointed expectations often trigger this behavior. Unstable interactions with mother can precipitate a typical sequence of forearm cutting, called “crash-flash-slash-gash.” The author outlines therapeutic interventions to interrupt this cycle between disappointing interaction and cutaneous self-injury.

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In 1990 we advanced the hypothesis that frightened and frightening (FR) parental behavior would prove to be linked to both unresolved (U) adult attachment status as identified in the Adult Attachment Interview and to infant disorganized/disoriented (D) attachment as assessed in the Ainsworth Strange Situation. Here, we view and to infant disorganized/disoriented attachment as frightened and frightening (FR) parental behavior, placing the infant in a disorganizational approach-flight paradox. We suggest that, being linked to the parent’s own un-integrated traumatic experiences (often loss or maltreatment), FR behaviors themselves are often guided by parental fright, and parallel the three “classic” mammalian responses to fright: flight, attack, and freezing behavior. Recent studies of U to FR, as well as FR to D relations are presented, including findings regarding AMBIANCE/FR+. Links between dissociation, FR, U, and D are explored. Parallel processing and working memory are discussed as they relate to these phenomena.

Reprints: Erik Hesse, Department of Psychology, 3210 Tolman Hall #1650, University of California, Berkeley, CA 94720-1650, USA.


The present study investigated the consistency of self-reports of childhood traumatic events in a sample of 50 patients with a borderline personality disorder (BPD) before and after 27 months of intensive treatment with schema focused therapy or transference focused psychotherapy. The mean number of reported sexual, physical and emotional traumatic events did not change following treatment. Test-retest correlations of the trauma-interview also indicated high stability of the total number of sexual, physical and emo-

tional events reported. The majority of the patients, however, did no longer report at least one of the 33 listed events after psychotherapy, and the majority reported at least one event that they had not mentioned before the start of treatment. These findings were not related to type of treatment or changes in suppression, intrusions, avoidance of intrusions, dissociative symptoms, depressive symptoms, and borderline symptoms.

Reprints: Ismay Kremers Department of Psychology Leiden University P.O. Box 9555 2300 RB Leiden, The Netherlands.


The trajectory of posttraumatic stress disorder (PTSD) and PTSD-related symptoms in relation to aging is not well understood. We previously observed higher levels of dissociation as measured by the Dissociative Experiences Scale (DES) among older Holocaust survivors with, compared to those without, PTSD, though scores on the DES in Holocaust survivors were markedly lower than those that had been reported for younger cohorts. We undertook a longitudinal evaluation of dissociation in Holocaust survivors. Twenty-six Holocaust survivors with current PTSD, 30 Holocaust survivors without current PTSD, and 19 non-exposed were evaluated at the initial evaluation and subsequently 8.11 years later. Repeated measures analysis of variance (ANOVA) on the DES scores from these times demonstrated a significant main effect for time and a significant group by time interaction, reflecting a marked decline in Holocaust survivors, particularly those with PTSD. Controlling for age obliterated the effect of time, but not the group by time interaction. A similar pattern was shown with The Clinician Administered PTSD Scale (CAPS) scores. Different symptoms related to PTSD show different trajectories of change with age, with dissociation appearing to be less prominent with age.

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This study evaluated the efficacy of paroxetine for symptoms and associated features of chronic posttraumatic stress disorder (PTSD), interpersonal problems, and dissociative symptoms in an urban population of mostly minority adults. Adult outpatients with a primary DSM-IV diagnosis of chronic PTSD received 1 week of single-blind placebo (N = 70). Those not rated as significantly improved were then randomly assigned to placebo (N = 27) or paroxetine (N = 25) for 10 weeks, with a flexible dosage design (maximum 60 mg by week 7). Significantly more patients treated with paroxetine were rated as responders (14/21, 66.7%) on the Clinical Global Impression-Improvement Scale (CGI-I) compared to patients treated with placebo (6/22, 27.3%). Mixed effects models showed greater reductions on the Clinician-Administered PTSD Scale (CAPS) total score (primary plus associated features of PTSD) in the paroxetine versus placebo groups. Paroxetine was also superior to placebo on reduction of dissociative symptoms [Dissociative Experiences Scale (DES) score] and reduction in self-reported interpersonal problems [Inventory of Interpersonal Problems (IIP) score]. In a 12-week maintenance phase, paroxetine response continued to improve, but placebo response did not. Paroxetine was well tolerated and superior to placebo in ameliorating the symptoms of chronic PTSD, associated features of PTSD, dissociative symptoms, and interpersonal problems in the first trial conducted primarily in minority adults.

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This study sought to determine the prevalence of dissociative disorders among women in the general population. The Dissociative Disorders Interview Schedule (DDIS), the Borderline Personality Disorder section of the Structured Clinical Interview for DSM-III-R Personality Disorders (SCID-II), and the PTSD-Module of the Structured Clinical Interview for DSM-III-R (SCID) were administered to 628 women in 500 homes. The mean age of participants was 34.8 (S.D.=11.5, range: 18-65); 18.3% of participants (n=115) had a lifetime diagnosis of a dissociative disorder. Dissociative disorder not otherwise specified (DDNOS) was the most prevalent diagnosis (8.3%); 1.1% of the population was diagnosed as having dissociative identity disorder (DID). Participants with a dissociative disorder had borderline personality disorder, somatization disorder, major depression, PTSD, and history of suicide attempt more frequently than did participants without a dissociative disorder. Childhood sexual abuse, physical neglect, and emotional abuse were significant predictors of a dissociative disorder diagnosis. Only 28.7% of the dissociative participants had received psychiatric treatment previously. Because dissociative disorders are trauma-related, significant part of the adult clinical consequences of childhood trauma remains obscure in the minds of mental health professionals and of the overall community. Revisions in diagnostic criteria of dissociative disorders in the DSM-IV are recommended.

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The goal of the current study was to investigate subjective and neurohormonal reactivity to acute psychosocial stress in borderline personality disorder (BPD) as a function of dissociative symptoms. Five BPD subjects with high dissociation, 8 BPD subjects with low dissociation, and 11 healthy control subjects were compared in basal urinary cortisol and norepinephrine, as well as in plasma cortisol and norepinephrine reactivity to the Trier Social Stress Test (TSST). Subjective stress rating and emotional response to the TSST were also measured. The three groups differed significantly in cortisol stress reactivity, with the high-dissociation BPD group demonstrating the most robust response. The three groups did not significantly differ in norepinephrine stress reactivity. In the combined BPD sample, dissociation severity tended to be inversely correlated with basal urinary norepinephrine, was positively correlated with norepinephrine stress reactivity. Childhood trauma was inversely correlated with basal urinary cortisol. In conclusion, despite its small sample size this pilot study suggests that dissociative symptomatology may be a marker of heightened biological vulnerability to stress in BPD, and merits further study.

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OBJECTIVE: Smaller hippocampal volume has been reported in several stress-related psychiatric disorders, including posttraumatic stress disorder (PTSD), borderline personality disorder with early abuse, and depression with early abuse. Patients with borderline personality disorder and early abuse have also been found to have smaller amygdalar volume. The authors examined hippocampal and amygdalar volumes in patients with dissociative identity disorder, a disorder that has been associated with a history of severe childhood trauma. METHOD: The authors used magnetic resonance imaging to measure the volumes of the hippocampus and amygdala in 15 female patients with dissociative identity disorder and 23 female subjects without dissociative identity disorder or any other psychiatric disorder. The volumetric measurements for the two groups were compared. RESULTS: Hippocampal volume was 19.2% smaller and amygdalar volume was 31.6% smaller in the patients with dissociative identity disorder, compared to the healthy subjects. The ratio of hippocampal volume to amygdalar volume was significantly different between groups. CONCLUSIONS: The findings are consistent with the presence of smaller hippocampal and amygdalar volumes in patients with dissociative identity disorder, compared with healthy subjects.

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The authors examined hippocampal and amygdalar volumes in patients with dissociative identity disorder, a disorder that has been associated with a history of severe childhood trauma. METHOD: The authors used magnetic resonance imaging to measure the volumes of the hippocampus and amygdala in 15 female patients with dissociative identity disorder and 23 female subjects without dissociative identity disorder or any other psychiatric disorder. The volumetric measurements for the two groups were compared. RESULTS: Hippocampal volume was 19.2% smaller and amygdalar volume was 31.6% smaller in the patients with dissociative identity disorder, compared to the healthy subjects. The ratio of hippocampal volume to amygdalar volume was significantly different between groups. CONCLUSIONS: The findings are consistent with the presence of smaller hippocampal and amygdalar volumes in patients with dissociative identity disorder, compared with healthy subjects.
time of their parent’s cancer diagnosis. Seventeen percent met screening criteria for likely PTSD. As hypothesized, PTSD symptoms were strongly and positively correlated with peritraumatic dissociation. Furthermore, PTSD symptoms were greater among females and were related to greater use of denial and behavioral disengagement and to less satisfaction with social support. These results suggest that health care providers need to recognize symptoms of peritraumatic dissociation in the children of parents who are diagnosed with cancer so that steps can be taken to minimize the children’s development of cancer.


References


Critical Issues continued from page 5

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