The International Society for the Study of Dissociation

NEWS

Volume 23, Number 4 July/August 2005

Inside:

YOUR SOURCE FOR UP-TO-DATE INFORMATION ON COMPLEX TRAUMA AND DISSOCIATION

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From the President

Recognizing Dissociation in Preschool Children

As I look out the window of my Northern Michigan home, it's the beginning of the blooming season, which occurs in late May here. I admire the spring flowers while pondering their indomitable ability to survive in spite of the frigid winds and heavy snow that blow off of Lake Superior. I am always amazed to see the delicate tender shoots of crocuses that emerge when this snowy Northern landscape finally thaws. As a weekend gardener, I realize how delicate yet tenacious the tulips, primroses and daffodils must be to bloom once again. However, upon closer scrutiny, I notice that some of the daffodils' stalks are green but there are no golden flowers atop. I don't really know why they didn't bloom this year, but I am reminded how vulnerable flowers are to a severe environment. To maximize their beauty and strength, just the right amount of water, sun, rich soil and, of course, fertilizer are needed. Absence of one of these environmental elements can leave the plants dwarfed and fragile, or not blooming at all. The development of these early bloomers is susceptible to a myriad of factors, genetic and environmental, the later in particular either nourishing or inhibiting their growth.

As I ponder the emerging beauty of the spring and the intricate balance it reflects, I recognize how symbolic it is of the right amount of nourishment, security, and stability required in a child's environment for healthy growth and a strong identity. The vulnerable young children I have treated over 30 years have experienced turbulence, unpredictability, and repeated traumas leaving them fragile, dissociated, and undeveloped without exuberance like the daffodils without their flowers.

In the past, there was scant literature on preschool childhood dissociation (Riley & Mead, 1988; Silberg, 1998; Shirar, 1996; Putnam, 1997; Macfie, et al., 2001a; Macfie, et al, 2001b; Haugaard, 2004) but since the development of the classification of Disorganized (D) Attachment (Main & Hesse, 1990, Main & Solomon, 1990), there has been more attention to this population, as dissociative responses are characteristic of D attachment with infants and toddlers. They display a disorganized, chaotic response to their parents marked by wanting to reach out to them, while switching to freezing, staring off, backing away and/or collapsing when the parent approaches (Solomon & George, 2001). The theoretical conceptualization that D attachment may lead to the development of a fragmented self (Liotti, 1992, 1999a, 1999b) appears to be supported by longitudinal studies showing that children with avoidant or D attachment may develop dissociative characteristics (Ogawa, et al. 1997, Carlson, 1998). The research examines various attachment styles, and the mother-child relationship as a mediator or predictor of the development of dissociative symptoms in the child. Avoidant or disorganized attachment may in turn predispose the child to a dissociative response to trauma (Barach, 1991; Liotti, 1999a, 1999b).

Very young children can neither soothe nor protect themselves, and do not have the mobility to seek out another caregiver.

Also, research indicates that infants and very young children are more prone to dissociate because they don't have the coping mechanisms to handle fearful or stressful situations independently (Solomon & George, Eds., 1999, Perry, 2001; Lyons-Ruth, K., 2003; Lyons-Ruth et al, 2004;

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Ogawa, et al., 1997, Carlson et al, 1989). The attachment system motivates the child to approach the parent whenever distressed. Very young children can neither soothe nor protect themselves, and do not have the mobility to seek out another caregiver. If a parent responds in a frightening or contradictory manner, the child can neither approach the caregiver for comfort not flee the very person on whom his life depends. The child's limited cognitive and behavioral systems for maintaining attachment may break down, leading to dazing, confusion, and rapid alternation between approach and avoidance. These disorganized responses appear to activate the neurophysiological mechanism which involves dissociative adaptive response, i.e. staring, unresponsivity, hypalgesia, depersonalization, and derealization (Perry, 2001). This calls for clinicians to be particularly heedful of dissociative indicators in infants and young children given their neurobiological capacity to dissociate when in the face of persisting threat. Yet, the significance of their responses often continues to be minimized or misinterpreted (Waters, 2005) because professionals erroneously believe that this population, contrary to current research isn't affected by frightening or/and unresponsive caretakers. Understanding symptoms of disorganized attachment are crucial to early detection and intervention of dissociative processes with preschool children.

It is important to consider whether their regressed behavior is indicative of a younger dissociated state.

The following are some prominent indicators of dissociation (Putnam, et al, 1993) in preschool children followed by an analysis of a case study.

- Staring, spacing out or trance-like states, including inattention
- Amnesia
- Extreme fluctuations in emotions and behaviors, including "regressive behaviors"
- Dissociative states or self states, including internal voices, referring to self in third person, and the importance of distinguishing between imaginary playmates and dissociated self states

I poignantly recall the first preschool case that I diagnosed in 1988 with Dissociative Identity Disorder, before the development of the Child Dissociative Checklist (Putnam, et al, 1993) and much published literature on the subject (Kluft,, 1984; Kluft,, 1985). Katie[1] was a bright and articulate three year old child in foster care whom I had assessed, treated and for whom I subsequently submitted a court report. Over time, she disclosed to me multiple traumatic events, i.e. sexual abuse by mother's boyfriend at 3 years old, and later disclosed sexual abuse by her biological father (convicted of sexual abuse of an older daughter) when she was a year and a half old. She was also neglected, and physically and emotionally abused by her mother and mother's boyfriend.

Katie would sit for extended periods of time staring into space and non-responsive. She would talk out loud to herself referring to herself in the third person. She displayed extreme shifts in mood and behavior marked by sudden angry outbursts over minor requests, uncharacteristic of her usual pleasant behavior. During these outbursts, she would attack her younger brother and then adamantly deny it, crumbling on the floor and extremely distraught that she was unfairly accused. At other times, she would regress into baby talk, particularly after supervised visits with her biological mother. She had episodes in the morning in which she would frantically try on different clothing, particularly underwear and slacks, crying hysterically stating that "Nothing felt right." No amount of prior agreed selection of an outfit or any reasoning was able to prevent her from escalating into hour-long episodes of chaotic, disoriented behavior to resolve what to wear. Meal times were occasionally stressful because she would suddenly not like her favorite food, macaroni and cheese, and would want something else to eat. She had severe insomnia and would literally hold open her eye lids to deter herself from going to sleep for fear of reoccurring nightmares. Most of these symptoms were exacerbated after visits with her biological mother.

My epiphany occurred (when I realized that Katie had Dissociative Identity Disorder) when she was in one of her 'regressed states' crawling on the floor engaging in baby talk and mumbling that she needed "to potty." She extended her hands for me to carry her to the bathroom, which I proceeded to do. When we entered the lobby where her foster mother of 6 months was waiting, I paused with Katie in my arms to inform her foster mother that we were on our way to the bathroom. Katie looked frightened at the 'stranger' and turned away refusing to talk to her stunned foster mother while wrapping her small arms tightly around my neck. Although I had been recognizing and diagnosing older dissociative children for a few years at this time, I misconstrued Katie's younger dissociative state as 'regressed behavior.' When, I reviewed the court report, I found that I had indeed described such behavior, i.e. baby talk, crawling, but had not recognized the significance of what I had seen until I witnessed Katie's amnesia for her foster mother. It was at that pivotal moment when the true meaning of her behavior crystallized for me in an accurate diagnostic picture.

A reconceptualization of Katie's misunderstood, regressed behavior and other symptoms opens the door to discussing multiple challenging factors involved in accurately assessing preschool children for dissociation. For a variety of reasons, it is frequently difficult to understand the meaning of young children's dissociative behaviors. It is important to consider whether their regressed behavior is indicative of a younger dissociated state. The evaluator needs to distinguish developmen-

[1]Client's name is a pseudo name

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ISSD Psychotherapy Training Program Launches New Initiatives

The Dissociative Disorders Psychotherapy Training Program (DDPTP) is proud to announce the addition of new Directors, new Programs, and new plans for expansion of our efforts. We've got a good thing going, and we are determined to make it better. We are proud to be able to offer a high quality educational experience for member and non-member clinicians and to "level the playing field" through educating ourselves and our peers. The dividend this reaps for current and future patients is a wonderful thing.

New Directors

Originally, Liz Bowman and Rich Chefetz shepherded this course into existence based upon the eleven month long course Liz taught from her office in Indianapolis. Each year, the Basic DDPTP has had around 18 face-to-face seminar sites in North America, Europe, and the Middle East. Steve Frankel joined Liz and Rich as a Director, two years ago, and has now completed the design and piloting of the Advanced DDPTP, to be offered next Fall at a number of locations (see below). The online course that Rich designed now has two sections running concurrently, but staggered with a Fall start and a Winter start. Over 50 students are working online at a given time. There has also been active planning to add a modular course to teach an Introduction to the Dissociative Disorders without the current requirement that participants have already treated someone with a dissociative disorder. We are hoping to teach this via the internet, using streaming video, and the course is very early in development. In addition, we have been talking with Daniel Mosca and Eduardo Cazabat, in Buenos Aires, about creating a Spanish version of the Basic DDPTP. With all this happening, two more Directors were added in the Spring with approval by the Executive Council. Both are well known teachers, Elizabeth Howell, and Eli Somer. Elizabeth will take over responsibilities for the basic DDPTP course, and Eli will work on development of courses to meet International needs. We anticipate waiting for his presidency to end before he gets fully up to speed on that task.

New Courses

We are pleased and excited that the DDPTP-A (Advanced) has been piloted in two locations: Davis, CA (with Steve Frankel) and Cincinatti, OH (with Don Beere). Based on the reactions to the course by participants and faculty, we are planning to offer the Advanced Course at between five and seven locations, beginning fall, 2005. As of this moment, we have definite plans to offer the Advanced course in Chapel Hill, N.C., Montreal, and New York. with strong possibilities in Duisburg, Germany, Washington, DC, the UK and San Francisco Bay area. The Advanced Course has been designed to build upon the material learned in the Basic Course and is also open to experienced clinicians with permission of faculty. Emphasis is on selected readings and extensive case discussions, with senior faculty colleagues facilitating the course meetings.

The Directors are currently negotiating with Fran Waters and Joyanna Silberg regarding their launch of a pilot for a Child and Adolescent DDPTP. The initial pilot will be offered in the Upper Peninsula of Michigan by Fran, and in Baltimore by Joy. A number of options for later multimedia and web casting versions have been discussed in a preliminary manner. In all these discussions the focus has been on how to deliver these educational products to the widest number of people at the same time that we don't burn out our faculty. It is an interesting and exciting process.

Expanding Efforts: It seems like there is increasing interest in the online sections as well as the possibility of additional online distribution of course seminars through streaming video. The technical specifications are coming more and more within the reach of lower budget operations, like ours, and as always, there is the factor of maintaining the "people power" behind the efforts that make all this possible. The DDPTP has been blessed with a lot of hardworking faculty, and great support at Headquarters from Michele Biesiada. We're always trying to improve our products and be responsive to students and faculty.

Fall 2005 and Beyond

To see where the sites for the Basic and Advanced Courses will be, take a look at www.issd.org under ***For The Professionals: Psychotherapy Training***. By the time you read this newsletter, registration will be open for our Fall classes, including the online section, which will be a Basic class in the Fall, and perhaps an Advanced class in the Winter. We invite you to participate, and to tell a colleague, especially if they are not an ISSD member, about our programs, and invite their participation. Special discounts are available for first time membership and course registration. The DDPTP will have a presentation during the Toronto meeting, so come by and talk with us about learning about the dissociative disorders in the DDPTP community!

ISSD NEWS
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Thank you to Sheppard Pratt Health Systems for their generous sponsorship of the ISSD News

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tally inappropriate behavior that may, for example, be an imitation of a new baby in the home from sporadic or frequent extreme switching of atypical behavior, particularly when accompanied by amnesia. Some young children may not exhibit such behavior on a regular basis but the significance of aberrant behavior must be examined carefully, particularly if the child has a trauma history. Katie was an articulate child with good, expressive language. When she uttered singular words and crawled instead of walking, I was struck with this unusual behavior.

For example, Katie's adamant refusal to eat her favorite food is not in itself unusual for children who display oppositional responses, particularly when tired, sick or simply wanting to assert independence. However, what is often characteristic of dissociative children is the extreme degree of such changes in preferences and the accompanying intense affective response. Dissociative children will often become inconsolable and quickly deteriorate.

Children's triggers may be disguised by their strong oppositional reactions, but a clinician must not assume that the traumatized child simply wants her way

Katie's frenzied search to find comfortable and acceptable apparel was another clue to some dissociative switching among self states. She was able to identify these self states, ranging in ages from one year old to adult, the latter representing her abusers. There was an internal struggle with her self states to take control over what to wear. In addition, Katie's comment, "Nothing feels right," pertaining to anything binding in her abdominal and genital areas was a traumatic reminder of her sexual abuse. I have observed repeatedly this hypersensitivity to clothing in traumatized children who are triggered by sensory stimuli.

Children's triggers may be disguised by their strong oppositional reactions, but a clinician must not assume that the traumatized child simply wants her way. Also, the child's staring, inattention and/or frenzied activity may be misdiagnosed as Oppositional Defiant Disorder or Attention Deficit Hyperactivity Disorder. If professionals focus primarily on these disruptive behaviors without understanding the contextual relationship between parent and child, as well as the underlying connotations, they may miss their true significance. Then if they employ a strictly behavioral approach, it is likely to be ineffectual. The occurrence of maltreatment and the resulting dissociative mechanisms may easily be overlooked and at worst persist.

Katie's amnesia for aggression toward her brother reflects a frequent indicator of dissociative children, one often misunderstood. Dissociative children's amnesia for assaultive behavior or "forgetfulness" can easily be misconstrued by weary, frustrated, and angry caregivers who assume that their children's denial is an escape from responsibility for their behavior. After dissociative children receive consequences for destructive acts, they will frequently persist in their denial of such behavior even though there isn't any benefit for them to continue. They may also repeat similar aggressive behaviors and be unresponsive to appropriate child management techniques. When astute clinicians see the entire picture of the pernicious impact of child maltreatment, they can understand that disavowal of behavior that others have clearly witnessed is one of the features of dissociation, rather than assuming that the child is simply defiant.

Katie's amnesia toward her foster mother was a potent and florid indicator of a separate dissociative state, rather than regressed behavior. This leads the discussion to discerning between imaginary playmates, fantasy play and dissociative states in young children. Research indicates that at age three, children can distinguish fantasy from reality (Harris, et al, 1991). The formation of separate self states to manage traumatic events with frightened children may develop from early and continued reliance on imaginary playmates (Putnam, 1985). While it is developmentally common for young children to have imaginary playmates, there are some distinguishing differences between imaginary playmates and formation of self states. Dissociative children's tenacious assertion that the dissociative states are real is one of the prominent responses I and others (Frost, et al 1996) have observed in young traumatized children who exhibit dissociative states, contrary to children who engage in fantasy play. For example, when I query the latter group in play therapy whether their expressed self-ascribed name is "real," they will look at me in a perplexed way, and respond, "No, silly. I'm just pretending." They will resume their fantasy play *without any disturbance of affect*. However, young children with DID are more likely to argue and persist that their self states are real and are separate from themselves. They become very impatient when attempts are made to explain otherwise and are insistent about their separateness. In addition, they will exhibit other dissociative symptoms described above providing a composite picture meeting the criteria for a dissociative disorder.

Another challenge in accurate diagnosis of this age group is that their dissociation can easily be misinterpreted and camouflaged due to linguistic deficits (Chicchetti & Beeghly, 1987; Beeghly & Cicchetti, 1994; Yehuda, 2005), and as yet undeveloped cognition, which may, in turn, have been impaired by maltreatment and a chaotic environment. These children's troubling presentation can be easily misconstrued and misdiagnosed as a pervasive developmental disorder, missing the significance of their dissociative behaviors and perhaps yet undiscovered trauma.

Complicating environmental factors can also hinder a correct diagnosis. It is a taxing process to gather a comprehensive child developmental history from caretakers – biological, foster or adoptive– who may not be attuned to the child, may misinter-

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pret the meaning of their child's disturbed behaviors, or do not have such history. Worst of all, caretakers may be either directly or covertly involved in their child's maltreatment. The clinician needs to carefully investigate this possibility while simultaneously evaluating the following: family dynamics, quality of the family relationships (particularly parental attachment history), parents' relationship with their child, and environmental influences, i.e. domestic violence, mental illness, substance abuse, and caretaker's overinvestment of the child's dissociative responses that maintain the child's dissociation (Peters, et al 1998). Assessing the quality of family relationships is particularly significant because these relationships may contribute to the formation of disorganized attachment with the child, which may predispose the child to dissociate.

This evaluation process must also be accomplished under the umbrella of an empathetic approach so as not to malign the child's caregivers. Not a simple task! However, the use of the Child Dissociative Checklist (Putnam, et al 1993) can be very helpful to the parents and clinician in detecting dissociation with young children and a springboard for more thorough discussion of dissociative indicators. Educating the parents about dissociation is paramount to helping them persevere in a loving and accepting manner with their child (Waters, 1996), while also being empathetic to the challenges of raising such a child. This approach needs to be accompanied with compassion for the child's struggles.

Diagnosing preschool dissociative children is critical to sparing them a lifetime of pain, agony and confusion. Like damaged tender spring shoots that regain their strength and vitality with proper care, so can young dissociative children demonstrate amazing resilience. They can recover from traumatic experiences and regain their spark. With early detection, a safe and nurturing environment, and appropriate intervention, they can go on to bloom and flourish into fulfilling adulthood.

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International Column

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We continue this series of reports from different continents with an excellent write-up from Francesca Collins who is the ISSD World representative for Australia/New Zealand. Francesca is a Clinical Psychologist with about 20 various publications to her name. She established 'Dissociation Australia', a Component Group of ISSD, in April 2004 which presently has over 70 members.

This continues to be an exciting and expanding time for the International wing of ISSD.

The ISSD Executive Council is right behind the expansion of regional societies across the world to reflect the specific variations in expertise in research, training and treatment of dissociation. These cultural variations enrich our understanding of this complex area. We have so much to learn from each other and an ever increasing need to present as a united, if disparate, group.

By the time you read this column, an important meeting will have taken place in Germany of clinicians, researchers and others to put in place a European Regional Society of ISSD. Several European countries will be represented. I very much hope this will act as a springboard for other regional societies to form.

Our aim is to increase membership of ISSD and keep this society at the leading edge in our field. I would be delighted to receive comments, articles and bits of news from your locality. Please email or send by post to the above address.

AUSTRALIAN REPORT

Francesca Collins, PhD, MAPS

There is growing interest in dissociative phenomena among Australian clinicians and researchers. However, while public and private investment in psychological trauma has grown enormously in last twenty years, generally speaking, the Australian trauma literature makes very little reference to dissociative processes or the dissociative disorders. This may best be understood in the context of a public mental health system that allocates resources on the basis of diagnosis (predominantly depression and psychotic disorders) rather than need, and professional training programs that make only passing reference to the dissociative disorders.

In 1992, Australia adopted a co-ordinated national mental health system: the National Mental Health Plan 1992-1997. The original Plan had four strategic aims: 1) to focus services on the diagnosis, treatment and research of 'serious mental illnesses'; 2) deinstitutionalisation involving the decommissioning of stand-alone psychiatric hospitals and the development of community-based services; 3) the "mainstreaming" of mental health services into the general health system including the establishment of acute psychiatric inpatient wards in general hospitals with the goal of reducing stigma and improving service quality; and 4) the promotion of consumer and carer involvement in the mental health policy-making process. Each of these aims have been pursued with varying degrees of success. However, by 2002, Australia faced a severe shortage of publicly funded psychiatric beds with 30.4 dedicated beds per 100,000 residents. This figure is far below world standard; per 100,000 residents, Canada has 193 beds, New Zealand, 134, the US, 95 and the UK, 58.

The Plan has also been criticised for allocating services based on an individual's diagnosis rather than their unique needs. This practice led to the privileging, within the system, of psychotic and mood disorder diagnoses over other complex clinical presentations. Smith (2003) explains the situation:

> …public psychiatry has become focused on psychosis, ending a century-long broader perspective…The concept of "serious mental illness" emerged, with a narrow definition of disorders meeting that criterion. It became the basis for determining access to public services and the type of staff employed…[However], lobbying by the [Consultation-Liaison] psychiatry community…led to acknowledgement in the Second National Health Plan 1998 that some public mental health systems had erroneously equated severity with diagnosis rather than level of need and disability. (pp.150- 151)

Although some attempt was made to rectify this imbalance in resource allocation in the second (1998-2002) and third (2003-2008) National Mental Health Plans, the situation remains that access to acute hospital beds is effectively restricted to individuals deemed at immediate risk of harm to themselves and/or others, presenting as psychotic or severely depressed.

It should be noted that while the National Mental Health Plans explicitly endorses the classification systems of the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases, 10th edition, no reference is made in any of the Plans, to the dissociative disorders. It is not surprising, then, that a basic knowledge of dissociation and the dissociative disorders is not a requirement of psychiatry and psychology training in Australia. And this "absence of such coverage has helped maintain the assumption that such disorders [are] either rare or non-existent" (Middleton, 1996, p. 43); "as in medicine in general, what's not considered or looked for, usually won't be found" (Middleton, 1996, p. 46).

As Brown, Middleton, Butler and Driscoll (1996) point out, "while there is greater acceptance of dissociative disorders, they still prove difficult to recognise and diagnose, particularly where the prevailing clinical tradition gives them little emphasis, and they are not covered in depth any depth in psychiatric training" (p.273).

An encouraging development is the

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establishment of the Royal Australian and New Zealand College of Psychiatrists, Special Interest Group on Psychological Trauma. Formed in 1996, the Group sponsored the 2000 World Conference of the ISTSS in Melbourne, Victoria, and a national lecture tour by dissociation scholar, Onno van der Hart. The Group also plans to establish specialist post-graduate psychiatry training in psychological trauma.

In terms of the private mental health sector, the only dedicated hospital beds for sufferers of dissociative disorders are those in the Trauma and Dissociation Unit of the privately operated Belmont Hospital in Queensland. A small number of well-established dissociation-specific support organisations exist including the Dissociative Identity Society of South Australia, the New South Wales-based Merging All Parts and the nation-wide support group, Ritual Abuse Survivors and Supporters.

Research

The 1990s saw the commencement of dissociation research in Australia. To date, the greatest amount of research has been conducted in relation to normal and peritraumatic dissociation. This research emphasis on dissociation as a normal response to both everyday and extraordinary events can be seen as reflecting the Australian mental health community's reticence regarding the dissociative disorders. However, this picture is changing. Emerging areas of research activity include the forensic implications of dissociation, the neuropsychology of Dissociative Identity Disorder (DID) and the relationship between dissociation and alexithymia.

Legal scholar, McSherry has tackled the question of dissociative states and legal responsibility under Australian law (1998; 2004). Her work has focused upon the status under Australian law, of the “fleeting mental state”of “psychological blow” automatism; she notes that "there is some suggestion that automatism resulting from dissociation is now beginning to be raised as a matter of course in Australia, along with other defences such as provocation and/or self defence" (McSherry, 1998, p. 174). Under Australian law, an individual experiencing dissociation-related automatism at the time of the crime would be considered sane, but unable to fully control their actions. In contrast, the same person would, under Canadian law, be considered insane and unable to control their actions. The legal status of dissociation-related automatism clearly has huge implication for the defendant who successfully brings the defence of automatism. In Australia, the defendant would be acquitted; in Canada, the individual may be detained indefinitely in a secure psychiatric ward.

Preliminary investigations have commenced into the rate and severity of dissociation in juvenile prison populations. Walker (2002) administered the Adolescent Dissociative Experiences Scale to 58 young males aged 16 to 18; 29 participants were incarcerated juvenile offenders and 29 were drawn from the general population. The offender group reported significantly higher A-DES scores than the general population group.

Led by Joseph Ciorciari, the Swinburne University of Technology Centre for Neuropsychology has begun investigating EEG coherence (a measure of cortical connectivity) between host and alters in individuals diagnosed with DID. In one of their earliest studies (Hopper, Ciorciari, Johnson, Spensley, Sergejew & Stough, 2002), the team compared EEG coherence in DID individuals and professional actors who acted as if they were DID. Results revealed significant EEG coherence among genuine DID hosts and alters but not among acted-DID 'hosts' and 'alters'.

Finally, Clayton (2004) has investigated the relationship between dissociation and the five dimensions of alexithymia: Difficulty analysing, identifying, verbalising, emotionalising and fantasising emotions. In a university population, the author found that somatoform dissociation is predictive of alexithymia, especially in young males.

Dissociation Australia

The Australian Component Group of the ISSD, Dissociation Australia (DA), was established in April 2004 and now has over 70 members. DA membership comprises psychiatrists, psychologists, nurses, social workers, naturopaths and general practitioners from seven of Australia's eight states and territories (Tasmania is, as yet, unrepresented). As of April 2005, psychologist and ISSD member, Kymbra Clayton, has taken up the role of co-convenor DA along with the present author.

DA has an accessible, and well-accessed, web presence at www.arts.monash.edu.au/behaviour/dissociation. The Web site provides a complete listing of members, dissociation-related research activities, training opportunities and links to related organisations. The Web site has been particularly useful as a source of treatment referrals and information for practitioners and individuals affected by dissociation and dissociative disorders. DA members also have the opportunity to participate in an ongoing online forum via a Yahoo! Group at health.groups.yahoo.com/group/DissociationAustralia.

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Critical Issues: The Science of Childhood Sexual Abuse

Steven Gold Ph.D.

The publication of an article titled "The Science of Childhood Sexual Abuse" in the April 22nd issue of *Science* magazine (Freyd et al., 2005) is an event worthy of special notice for ISSD members for a number of reasons. *Science*, published by the prestigious American Association for the Advancement of Science (AAAS), was founded in 1848. The AAAS Web site (www.aaas.org) notes that the Association "serves some 262 affiliated societies and academies of science" and that *Science* "has the largest paid circulation of any peer-reviewed general science journal in the world, with an estimated total readership of one million." It therefore holds the unusual position of simultaneously enjoying a high level of respect in the scientific community, a large readership, and, consequently, appreciable impact.

The mere presence of an article on childhood sexual abuse (CSA) – a topic of obvious relevance to ISSD – in *Science* carries significance; it represents an important contribution in securing the topic in the minds of the public and the scientific community as a legitimate area of study with an established body of scientific research. It is sad that the scientific status topic of CSA should require justification. After all, a vast body of empirical data on the subject has now been accumulating for over a quarter of a century. Unfortunately, for many years the salience in the popular media of reports questioning the existence of CSA, the validity of recollections of CSA, and whether CSA is harmful have fostered an atmosphere which renders legitimization necessary.

Publication of this article in *Science* is especially noteworthy because the vast majority of the content of the publication is in areas of the natural sciences such as biology, astronomy and physics. Although the social sciences are represented, all together they routinely comprise a small proportion – less than 10% – of its content. This makes inclusion of an article on the beleaguered topic of CSA a major achievement indeed.

An even more direct link between this article and ISSD exists via its authors. The first author of the piece is Jennifer Freyd, incoming editor of ISSD's Journal of Trauma & Dissociation. Dr. Freyd is Associate Professor of the Department of Psychology and Institute of Cognitive and Decision Sciences of the University of Oregon. Second author Frank Putnam was a founding member of ISSD and has been a pioneer in the modern study of dissociation. He is Professor of Psychiatry and Pediatrics at the University of Cincinnati and Scientific Director of the Every Child Succeeds program at the Mayerson Center at Cincinnati Children's Hospital Medical Center. The remaining authors are: Thomas H. Lyons, Professor of Law, University of Southern California Law School; Kathryn A. Becker-Blease, Post-Doctoral Research Fellow at the University of New Hampshire Family Research Laboratroy; Ross T. Cheit, Associate Professor of Political Science and Public Policy, Brown University; Nancy B. Siegel, private consultant and Membership Chair of the Leadership Council on Child Abuse and Interpersonal Violence, and Kathy Pezdek, Professor, Department of Psychology, Claremont Graduate University. Clearly, they are an august group.

As is commonplace in this type of publication, the piece is extremely condensed but extensively referenced. It consists of a mere six paragraphs, each of which addresses a topic central to CSA: prevalence; adverse consequences; methodological considerations; factors that hamper detection; factors that inhibit synthesis of research findings; and financial and societal costs. Despite the brevity of the text, the article's content is supported by 36 citations.

Highlights in each of the first five areas covered by the article include the following findings and observations:

- Contact CSA has been reported by 20% of women and 5 to 10% of men, but almost 90% of CSA goes unreported to authorities.
- CSA has been found to be related to severe psychological and medical difficulties, increased incidence of victimization, and criminality later in life.
- Although research is complicated by numerous factors they frequently co-exist with CSA, such as other forms of victimization and family dysfunction, methodologically sound studies document its unique contribution to long term adverse consequences.
- Detection is greatly hampered by the fact that in the majority of instances the perpetrator is someone the child is emotionally attached to, which fosters lack of support by caretakers, impaired recall of CSA, and delayed reporting, compromising the credibility of disclosures of victimization.
- Coordination and synthesis of findings on CSA is impeded by the fact that several disciplines are actively engaged in studying it, so that literature on the subject is scattered in the publications of diverse professions.

Most importantly, the authors conclude with two ambitious recommendations. One is the establishment of an institute at NIH for the study of child abuse and interpersonal violence. The other is extension of the National Child Traumatic Stress Network, a system of 54 affiliated community-based institutions that deliver treatment to traumatized children and families. The rest of the article leads up to and culminates in these two proposals.

In this respect the article not only is well constructed and substantive, but it also serves as a model for strategically addressing those factions that try to counter the credibility of science-based information on CSA. Succinctly put, the piece is pro-active and constructive

Critical Issues continued from page 8

rather than reactive. This general approach is based on a number of identifiable principles:

1) The body of the piece stays focused on information rather than on argumentation.
2) The information conveyed is documented with scientific findings.
3) Points are stated simply and directly, with a minimum of rhetoric or sensationalistic language.
4) The information provided culminates in specific, measurable, constructive solutions to the problem of CSA.
5) The piece is framed on the authors' terms rather than having been structured in a reactive fashion as a rejoinder to detractors.

While all these principles contribute to the value of the piece, it is this last one that deserves particular recognition. For too long, those of us who study abuse, trauma and dissociation allowed critics to distract us from the efforts that would have moved these fields forward, while we became caught up in responding to their attacks and defending our position. It was a costly mistake that not only slowed these areas of study but proved to be largely ineffective in persuasively conveying our message to the scientific community and the general public. It is not difficult to imagine that the publication of this piece will one day be looked back on as a decisive turning point. It may mark the moment when we learned that the truth is best served when we frame the terms of our communication, rather than allowing it to be shaped by those who are invested in obscuring, distracting attention from and distorting the sources of pain and injured that we have devoted ourselves to addressing.

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It's the Infrastructure, Stupid!

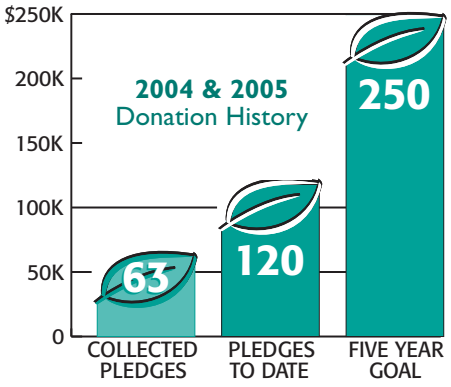
or, Episode III: The Revenge of the Conservative

Tom Tudor, Ph.D.
Chair, ISSD Development Committee

Much to teach us, the Republican Party has. Republicans control both houses of Congress and the Presidency, not because of luck, bad Democratic candidates, or having a lot of money. Whether you are a Democrat or Republican or have another orientation, politics aside, it is easy to see why the Republicans have had such success. It is a direct result of 40 years (since Goldwater's defeat in 1964) of building infrastructure to support their political beliefs. They created institutes (43) both within and outside of universities, supported authors who wrote books, supported interns, and helped young conservatives get jobs. They spent four times the amount of money on research and media time than the progressives. Eighty per cent of the talking heads on television are from conservative think tanks.

ISSD has the skeleton of infrastructure. We have a 21 year-old organization, a stable membership, a journal, a network of study groups, a psychotherapy training program, and conferences. However, we need to flesh out this skeleton to achieve our education and research goals. We have decided to create the Center for the Study of Chronic Traumatization and Resilience. We want to create a series of educational videotapes and widely distribute them. We want to substantially expand our Web site and make creative use of the internet and web. We want to create a comprehensive treatment manual and a wide variety of educational materials.

So we are left with the "F" word. No, not the Force. Finances. We need money to continue to flesh out our skeleton of infrastructure. Our Development Campaign is in its second year. We've had some success. Will you help us get to the next level?



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The ISSD 22nd International Fall Conference

Nov. 6-8, 2005
Toronto, Ontario, Canada
Toronto Marriott Eaton Centre

Paul F. Dell, PhD
Daphne Simeon, MD, PhD
Conference Co-Chairs

Toronto, Ontario, Canada is the site of ISSD's 22nd International Fall Conference. Since the last newsletter, program submissions were received, sorted, reviewed, and scheduled by our able program committee. The preliminary conference brochure is now on its way to the printer and you should have it soon. You will see that it contains a panoply of fine programs on a wide variety of topics, spanning both clinical and theoretical/research areas, presented in paper, symposium, panel, forum and workshop formats. This year, like last, we have also included a poster session and evening programming.

As in previous years, submissions had a high level of rigor and sophistication; they continue the tradition of being useful to clinicians who are seeking new approaches and skills, as well as to theoreticians and researchers who are interested in new findings and new methodologies. This year's theme "**Dissociation across the Lifespan**" was chosen by our president, Fran Waters, who is a child specialist. The conference theme seeks to increase our clinical understanding and treatment skills of dissociation in childhood and adolescence in particular, and dissociation across the lifespan in general. Three of our four plenary speakers—Karlen Lyons-Ruth, Frank Putnam, and Fran Waters—have specialized in understanding the developmental roots of pathological dissociation and its treatment.

DISSOCIATION ACROSS THE LIFESPAN: JOURNEY TOWARD ACHIEVING INTERNAL AND EXTERNAL HARMONY

The conference subtheme, "Preparing for DSM-V," will be a recurrent one at ISSD conferences over the next few years. ISSD is working with scholars in the field of dissociation to bring the latest scientific findings to bear upon the rewriting of the Dissociative Disorders section of the DSM. Our fourth plenary speaker, Dr. Michael First, is the American Psychiatric Association's current leader of the DSM-V project. He will speak about the dissociative disorders and the DSM-V process on the final morning of the conference. He will also attend the evening panel on the second day of the conference: "ISSD's Hopes and Wishes for DSM-V." That panel will present to the conference the conclusions and recommendations of the first Dissociative Disorders Research Planning Conference that will be held in Toronto just prior to the ISSD conference.

The International Fall Conference will have considerable emphasis on the following topics: complex trauma and dissociation in childhood and adulthood, attachment issues as related to parenting and dissociation, personality implications of chronic abuse and trauma, domains and predictors of dissociation, assessment instruments and methods, and developing theoretical hypotheses and formulations. Workshops will stress various treatment modalities including: psychodynamic approaches, hypnosis, EMDR, creative techniques; special issues such as eating disorders and other forms of compulsivity, self injury, addictions, and chronic pain; and special populations such as children and adolescents, parents, couples, and "impossible patients". Several offerings are focused on therapists as healers and issues of vicarious traumatization, risk management, and healing for the healer. As in previous years, an all-day introductory course will address the assessment, diagnosis, and treatment of complex dissociative disorders.

A little about the hotel, conference economics and conference guides

Su Baker, MEd
Conference Manager

We are excited to be holding our annual fall conference for only the second time in Canada, this time in Canada's largest city, Toronto, Ontario. The conference will be held in downtown Toronto at the Marriott Eaton Centre Hotel. The hotel is part of the Eaton Centre, which stretches 2 full city blocks, is modeled on Milan's Galleria Vittorio Emanuele, and includes a 6-story glass structure with close to 300 stores. It is just a short hop to the waterfront, the CN tower, and the ISTSS hotel. The Marriott Eaton Centre is on one of many subway lines. We were able to negotiate an excellent price for this outstanding hotel, at $169 (CAD) single or double rooms. At this time, in US dollars, that is about $135. Our conference facilities are largely on a single floor with spacious foyers, which is excellent for socializing and visiting the exhibits between sessions.

We want to remind you that the ISSD counts on its attendees to stay at the ISSD hotel. In order to host the conference, we have to guarantee that our attendees will use most of the sleeping rooms in our "room block" (i.e., rooms that are kept aside for us), otherwise we must pay a large penalty fee. We try to negotiate the best contract that we can with the hotels so that we can keep costs within a reasonable range for both the attendees and the ISSD. We have done well in the past; this year, we have actually increased the number of rooms set

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aside so that everyone has the opportunity to stay at the hotel. Please make your reservations early; that makes it possible for us to arrange for even more space if necessary. You can reserve a room by calling Marriott reservations at 1-800-905.0667 (hotel number is 1-416-597-9200). **You must mention that this is for the ISSD conference in order to get the low conference rates**.

If you wish to share a room and are looking for a roommate, please contact Ellen (Rusti) Klein at rustik@bellsouth.net who will help you to find a roommate. This service is only for attendees staying at the Toronto Marriott Eaton Centre. You may also want to contact Rusti if you are a first time conference attendee and want a conference guide to help you "find your way," or if you wish to be a conference guide for first-time attendees. While ISSD attendees are usually a very warm and friendly group, it helps to have someone who has attended conferences in the past. We encourage anyone, especially non-North Americans to make yourself available as a conference guide. Many new friendships have started this way over the past few years. Rusti can give you more information and can match you with a first-time attendee.

We look forward to seeing you in Toronto!

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ISSD Atrium Listing

A new section has been added to the Atrium (members only) section of the ISSD Web site called *From the ISSD*.

Each month the ISSD News will list the current content posted in this section. Currently *From the ISSD* contains an obituary on ISSD member Lillian Gross, M.D. written by June Conboy, Ph.D.

Forensic Forum:
How I Learned to Stop Worrying and Love *HIPAA*

A. Steven Frankel, Ph.D., J.D.

A. Steven Frankel, Ph.D., J.D.
Philip J. Kinsler, Ph.D.,
Co-editors

When I last wrote to you about record-keeping, I covered the basic principles of record-keeping, including the balance between writing too much and too little, protecting patient privacy while meeting standards of care for mental health professionals, and some focused recommendations about ways to document patient attempts to "push" boundaries. Since that column appeared, the privacy component of the federal statute known as the *Health Insurance Portability and Privacy Act*[2] *("HIPAA")* has been implemented, confronting professionals with some decisions regarding the ways they keep records. In this article, I share my response to but one of those decisions – the decision to keep psychotherapy notes (aka "process notes").

With sincere apologies to *Caesar's Gallic Wars*[3] ***HIPAA*** holds that all mental health information is divided into two parts. First, we are all charged with keeping a "clinical record" (aka "medical record"), which includes: 1) anything that might be included on a health insurance claim form, 2) billing/financial records, 3) anything that might be included in a treatment summary (I've supplied the statutory definition of "treatment summary" enacted in California as a sample, so you can see the kinds of information that are considered relevant), 4) psychoactive medications (there is an interest in non-physician professionals becoming increasingly sensitive to medication involvement in changes in patient status), and 5) psychological testing results (including raw data, I'm afraid[4]).[5]

Second, we are given the option of keeping a second set of mental health records, called "psychotherapy notes" or "process notes" which are described as "notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session."[6] On close inspection psychotherapy notes are not to include the information described above as falling within the (exclusive) province of the "clinical record." Thus, the psychotherapy notes are not to include discussions of symptoms, treatment modalities, etc.

Further, psychotherapy notes are considered far more "private" than is the clinical record – so much so that they are required to be kept separate (physically/electronically) from the clinical record, and any release of information signed by a patient cannot be applied to the psychotherapy notes - the patient must sign a separate release for that purpose.[7] Finally, they are so private that *HIPAA* holds that insurance companies may not deny payment for services or the provision of future services solely because they have not been provided with psychotherapy notes.[8]

The fundamental rationale for providing us with an opportunity to keep a separate set of records about our patients is that "they are the personal notes of the therapist, intended to help him or her recall the therapy discussion and are of little or no use to others not involved in the therapy. Information in these notes is not intended to communicate to, or even be seen by, persons other than the therapist. Although all psychotherapy information may be considered sensitive, we have limited the definition of psychotherapy notes to only that information that is kept separate by the provider for his or her own purposes. It does not refer to the medical record and other sources of information that would normally be disclosed for treatment, payment, and health care operations."[9]

If that rationale makes sense to you, consider the following elaboration: "These notes are often referred to as 'process notes,' distinguishable from 'progress notes,' 'the medical record,' or 'official records.' These process notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be

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inappropriate for the medical record, and are used by the provider for future sessions. We were told that process notes are often kept separate to limit access, even in an electronic record system, because they contain sensitive information relevant to no one other than the treating provider. These separate 'process notes' are what we are calling 'psychotherapy notes.' Summary information, such as the current state of the patient, symptoms, summary of the theme of the psychotherapy session, diagnoses, and medications prescribed, side effects, and any other information necessary for treatment or payment, is always placed in the patient's medical record. Information from the medical record is routinely sent to insurers for payment."[10]

Thus, in a burst of clarity, we are offered the option of keeping records that would not "normally be disclosed for treatment," that would be of "little or no use to others not involved with the therapy, but are relevant to "future sessions." And, they are called both "psychotherapy notes and "process notes."[11]

Silly me. I always thought that process notes were narrative notes that articulated the dynamic forces at work within a patient, and how these forces played out in the transference. Now, however, I am enlightened. I realize that psychotherapy notes or process notes have virtually no definition that makes much sense, and I also know that, on a state-by-state basis, state law may override *HIPAA*'s protections. In California, for example, most of us health care law types urge mental health professionals to expect that anything they write (or record in any way) about a patient will likely be discoverable in legal proceedings, and that is why you may remember that my earlier column strongly cautioned against keeping process notes as I have understood them, as they provide wonderful opportunities for borderline-trained attorneys (find a kernel of hideous truth and blow it up until it fills the entire field) to dismember a professional under cross-examination.

But I have now seen the light. I have adapted. I have clarity about a way to use "psychotherapy notes" to assist my patients. I have begun with the template* created some years ago and generously shared by Laura Brown, Ph.D. – a template she developed for keeping an ongoing record of mental health contacts. I have separated out the information that *HIPAA* would say belongs in psychotherapy notes and now record that information on a separate template I advisedly call "psychotherapy note." And I use that piece of paper to assist my patients with two of the most significant areas of compromise affecting our patients as a group. I use it to help patients with continuity of memory for their work with me over time and with self-reflexivity ("observing ego," for those who speak that language). Because it doesn't have all the distracting material that appears on the "clinical record" template (which they are also free to see whenever they wish), I can point directly to my observations of the issues they "came in with" that day, what we did with those issues, and the things they said/did during the session that were, from my perspective, significant.

By calling these "psychotherapy notes," I can properly keep them from insurance companies (but not the courts), my patients can understand more about where they have come in treatment over what period of time, regarding which issues and they can get a sense of how they are "coming across" in our interactions. When they see that I have written something about a boundary issue (e.g., "I'm cold and exhausted after doing that trauma piece – I feel like I need to be held – can you just hold me?" "I replied…") I can share that my recording of that interaction means the therapy frame is safe, in that I am aware of what boundary issues are, what they mean, how to handle them, etc.

So, I spend a few minutes after each meeting with a patient filling out two pieces of paper: the clinical record and the psychotherapy note. I keep them stored separately. You will see that each is made up of a series of categories and lines for each category. Please understand that these are just lines on pieces of paper – not the gospel according to me. If I wish to write more, I do. If I wish to write less, I do. If you decide to use something like these templates, feel free to do so, but put no faith in their perfection. You get to make some decisions about using them, just as I have.

References

[1]Frankel, A.S. (2000). Noteworthy. *ISSD News, 18*(5), 8-9.

[2]45 CFR 160 et seq

[3]Caesar, J. (1962). *Caesar's Gallic War*, New York: Barron's Educational Series; Latin Edition

[4]The issues of psychological testing data, especially raw data and materials subject to copyright, are complex. There is very helpful material available on Ken Pope's Web site for those who are concerned. Go to http://www.kspope.com/ and click on "assessment".

[5]Or, in the language of government: *Federal Register* / Vol. 65, No. 250 / Thursday, December 28, 2000 / Rules and Regulations p 82497 "…medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis and progress."

[6]*Federal Register* / Vol. 65, No. 250 / Thursday, December 28, 2000 / Rules and Regulations p 82497 Psychotherapy Notes Section 164.508(a)(3)(iv)(A)

[7]See, e.g., *Federal Register* / Vol. 65, No. 250 / Thursday, December 28, 2000 and *Federal Register* / Vol. 65, No. 250 / Thursday, December 28, 2000 / Rules and Regulations Section 164.502.

[8]See *Federal Register* / Vol. 65, No. 250 / Thursday, December 28, 2000 / Rules and Regulations p 82516.

[9]*Federal Register* / Vol. 65, No. 250 / Thursday, December 28, 2000 / Rules and Regulations

[10]*Federal Register* / Vol. 65, No. 250 / Thursday, December 28, 2000 / Rules and Regulations Section 164.501 --- Definitions …pp 82605 – 82629 A. p 82623 Psychotherapy Notes Comment

[11]For a more complete discussion of these issues and access to FREE FORMS to help make your record-keeping system *HIPAA*-compliant, you might visit: www.americanmentalhealth.com. Then click on "Therapists" and then again on "HELP."

California Health & Safety Code 123130 holds that a treatment summary must include:

1 Chief complaint or complaints including pertinent history.
2 Findings from consultations and referrals to other health care providers.
3 Diagnosis, where determined.
4 Treatment plan and regimen including medications prescribed. **5** Progress of the treatment.
6 Prognosis including significant continuing problems or conditions.
7 Pertinent reports of diagnostic procedures and tests and all discharge summaries.
8 Objective findings from the most recent physical examination, such as blood pressure? weight? and actual values from routine laboratory tests.

*Samples of the templates can be found on the ISSD Web site

Publications of Interest: Recent Books and Articles

Stephanie Dallam, R.N., M.S.F.N.P.
Kathy Steele, M.N., C.S.
Co-editors

Dorahy, M. J., Irwin, H. J., Middleton, W. (2004). Assessing markers of working memory function in dissociative identity disorder using neutral stimuli: A comparison with clinical and general populations. *Australian and New Zealand Journal of Psychiatry, 38*, 47-55.

Objectives: Memory functioning is a central conceptual and phenomenological aspect of dissociative identity disorder (DID). Most empirical work on memory functions in DID has focused on retrieval deficits either within or between dissociated identities. The current study attempted to remedy the scant attention given to working memory functioning.

Method: In samples representing the DID, non-clinical, depressed, posttraumatic stress disorder (PTSD) and psychosis populations (n = 10 per group), neutral stimuli were used to examine three markers of working memory functioning: one measuring inhibition; one assessing facilitation; and one measuring interference.

Results: With the exception of the psychosis sample all groups displayed significant negative priming in the distractor inhibition condition. Facilitation effects were demonstrated by the DID and PTSD groups only. Interference effects were evident in all samples, though the DID and non-clinical groups demonstrated significantly more interference than the psychosis cohort. Distractor inhibition was related to overall schizotypy scores, and dissociation was related to scores in the facilitation condition.

Conclusions: The DID sample displayed a completely distinct functional working memory profile to the psychosis sample when assessed with emotionally neutral stimuli. However, the working memory profiles in the DID sample was not entirely dissimilar to the other comparison groups.

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Nixon, R. D. V., R. A. Bryant, Moulds, M. L., Felmingham, K. L., & Mastrodomenico, J. A. (2005). Physiological arousal and dissociation in acute trauma victims during trauma narratives. *Journal of Traumatic Stress 18*(2), 197-113.

The aim of the present study was to examine whether the finding of suppressed physiological activity in dissociative rape-trauma victims was replicable in a nonsexual assault trauma group. A sample of 17 high-dissociating (HD) participants and 18 low-dissociating (LD) participants who had experienced a motor vehicle accident or physical assault described their trauma while skin conductance, heart rate activity, and self-reported mood were recorded. HD individuals demonstrated a trend for elevated heart rate during the experiment compared with LD participants, but both groups displayed comparable skin-conductance levels. Curve estimation analysis indicated that the two groups had a similar pattern of physiological responding during the trauma narratives. These findings challenge the notion that dissociative reactions are associated with reduced psychophysiological arousal after trauma.

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Philipsen, A., Richter, H., Schmahl, C., Peters, J., Rusch, N., Bohus, M., & Lieb, K. (2004). Clonidine in acute aversive inner tension and self-injurious behavior in female patients with borderline personality disorder. *Journal of Clinical Psychiatry, 65*(10), 1414-9.

The acute effect of 75 and 150 mcg of clonidine administered orally in acute states of strong aversive inner tension and urge to commit self-injurious behavior was examined in 14 female patients meeting DSM-IV criteria for borderline personality disorder. Aversive inner tension and dissociative symptoms were assessed before and 30, 60, and 120 minutes after administration of clonidine using the Dissociation-Tension-Scale acute. The urge to commit self-injurious behavior and suicidal ideations were assessed using self-rating Likert scales. Blood pressure and heart rate were monitored during the trial. Results showed that aversive inner tension and urge to commit self-injurious behavior before administration of clonidine were strong. After administration of clonidine in both doses, aversive inner tension, dissociative symptoms, urge to commit self-injurious behavior, and suicidal ideations significantly decreased. The strongest effects were seen between 30 and 60 minutes after drug intake and correspond to the pharmacokinetics of clonidine with maximum plasma concentrations after 1 hour. Blood pressure and aversive inner tension and dissociative symptoms were positively correlated before and after administration of clonidine. It is concluded that clonidine may be effective for treatment of acute states of aversive inner tension, dissociative symptoms, and urge to commit self-injurious behavior in female patients with borderline personality disorder. Further placebo-controlled studies with larger populations are needed to confirm this finding.

Reprints: Department of Psychiatry and Psychotherapy, University of Freiburg, Germany.

Philipsen, A., Schmahl, C., & Lieb, K. (2004). Naloxone in the treatment of acute dissociative states in female patients with borderline personality disorder. *Pharmacopsychiatry, 37*(5), 196-9.

The effect of 0.4 mg naloxone administered intravenously in acute dissociative states was examined as compared to placebo in a double-blind crossover study in nine patients who met DSM-IV-criteria for borderline personality disorder (BPD). Dissociative symptoms before

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and 15 min after a single dose of naloxone or saline placebo were assessed using a self-rating instrument for dissociation and aversive inner tension (DSS) and the observer-based items of the Clinician Administered Dissociative States Scale (CADSS). Results show that dissociative symptoms before treatment with naloxone or saline placebo were moderate to severe. After injection of either naloxone or placebo, dissociative symptoms significantly decreased on the DSS ($p < 0.01$) and the CADSS ($p < 0.05$). However, there were no significant differences between naloxone and placebo in the reduction of symptoms. Patients who showed the most prominent response to naloxone fulfilled the highest number of DSM-IV-criteria for BPD. Although it is difficult to draw definite conclusions from this small sample of patients, this study does not support the assumption that naloxone in a single dose of 0.4 mg is superior to placebo in acute dissociative states in patients with BPD. Further studies will investigate whether patients benefit from naloxone in a higher dose or whether subgroups of patients with BPD profit from naloxone in acute dissociative states.

Reprints: Department of Psychiatry and Psychotherapy, University of Freiburg, Germany.

Piper, A., & Merskey, H. (2004). The persistence of folly: A critical examination of dissociative identity disorder. Part I. The excesses of an improbable concept. *Can J Psychiatry, 49*(9), 592-600.

In the first part of a two part review, the authors review the literature on dissociative identity disorder (DID) and conclude that: 1) there is no proof for the claim that DID results from childhood trauma; 2) the condition cannot be reliably diagnosed; 3) contrary to theory, DID cases in children are almost never reported; and 4) consistent evidence of blatant iatrogenesis appears in the practices of some of the disorder's proponents. They conclude that DID is best understood as a culture-bound and often iatrogenic condition.

Reprints: University of Western Ontario, London, Ontario.

Piper, A., & Merskey, H. (2004). The persistence of folly: Critical examination of dissociative identity disorder. Part II. The defence and decline of multiple personality or dissociative identity disorder. *Canadian Journal of Psychiatry, 49*(10), 678-83.

In this second part of a two part review, the authors continue to explore what they consider to be the illogical nature of the arguments offered to support the concept of dissociative identity disorder (DID). They also examine the harm done to patients by DID proponents' diagnostic and treatment methods. They suggest that current practices reify the alters and thereby iatrogenically encourage patients to behave as if they have multiple selves. They also examine the factors that they argue make impossible a reliable diagnosis of DID and suggest that because the diagnosis is unreliable, US and Canadian courts cannot responsibly accept testimony in favor of DID. Finally, they offer their opinion about the future of DID..

Reprints: University of Western Ontario, London, Ontario.

Punamäki, R.-L., I. H. Komproe, et al. (2005). The role of peritraumatic dissociation and gender in the association between trauma and mental health in a Palestinian community sample. *American Journal of Psychiatry 162*(3), 545-551.

OBJECTIVE: This research focused on gender-specific trauma exposure and mental health symptoms among Palestinians living in conditions of military violence. It also examined the gender-specific role of peritraumatic dissociation in moderating the association between lifetime trauma and mental health. METHOD: A random sample of 311 Palestinian women and 274 men ages 16-60 years from the Gaza Strip participated. The subjects were asked about lifetime trauma and peritraumatic dissociation during their most severe traumatic experience. Mental health was indicated by total scores and diagnostic variables of PTSD, anxiety, mood (depression), and somatization disorders. Symptoms of hostility were assessed as a total score. RESULTS: The women reported a lower level of lifetime trauma than the men, but exposure to trauma was associated with PTSD among both genders. Exposure to lifetime trauma was further associated with anxiety, mood, and somatoform disorders only among women but not among men. No gender differences were found in the level of peritraumatic dissociation. Analyses on moderating effects showed that peritraumatic dissociation made both men and women more vulnerable to symptoms of hostility and men to depressive symptoms when they were exposed to lifetime trauma. CONCLUSIONS: The results are consistent with previous studies in more peaceful conditions: men experience more traumatic events, whereas exposure is associated with more severe psychiatric disorders among women. Peritraumatic dissociation as an acute response to trauma constituted a risk for mental health symptoms in both genders.

Reprints: Raija-Leena Punamäki, Department of Psychology, University of Tampere, Tampere, Finland

Reich, D.B., Winternitz, S., Hennen, J., Watts, T., & Stanculescu, C. (2004). A preliminary study of risperidone in the treatment of posttraumatic stress disorder related to childhood abuse in women. *Journal of Clinical Psychiatry, 65*(12), 1601-6.

This study evaluated the effectiveness of risperidone in women for the treatment of posttraumatic stress disorder (PTSD) related to childhood physical, sexual, verbal, and emotional abuse. Subjects were outpatient adult women, aged 18 to 64 years, and with chronic PTSD related to childhood physical, sexual, verbal, or emotional abuse. Subjects were randomly assigned to receive risperidone ($N = 12$) in flexible daily dosages in the range of 0.5 to 8 mg or placebo ($N = 9$) for 8 weeks. Risperidone-treated patients had a significantly greater reduction in total score on the Clinician-Administered PTSD Scale (CAPS-2) ($z = -2.44$, $p = .015$). Risperidone-treated patients also had significantly greater reductions in the intrusive ($z = -5.71$, $p < .001$) and hyperarousal ($z = -2.74$, $p = .006$) subscale scores of the CAPS-2. The results of the current study indicate that low-dosage risperidone is a safe and effective treatment for intrusive and hyperarousal symptoms in adult women with chronic

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PTSD from childhood physical, sexual, verbal, and emotional abuse.

Reprints: Trauma and Dissociative Disorders Program, McLean Hospital, Belmont, MA 02478, USA. Email: reichb@mcleanpo.mclean.org

Sar, V., Akyuz, G., Kundakci, T., Kiziltan, E., & Dogan, O. (2004). Childhood trauma, dissociation, and psychiatric comorbidity in patients with conversion disorder. *American Journal of Psychiatry, 161*(12), 2271-6.

The aim of this study was to evaluate dissociative disorder and overall psychiatric comorbidity in 38 patients with conversion disorder. At least one psychiatric diagnosis was found in 89.5% of the patients during the follow-up evaluation. Undifferentiated somatoform disorder, generalized anxiety disorder, dysthymic disorder, simple phobia, obsessive-compulsive disorder, major depression, and dissociative disorder not otherwise specified were the most prevalent psychiatric disorders. A dissociative disorder was seen in 47.4% of the patients. These patients had dysthymic disorder, major depression, somatization disorder, and borderline personality disorder more frequently than the remaining subjects. They also reported childhood emotional and sexual abuse, physical neglect, self-mutilative behavior, and suicide attempts more frequently. It is concluded that comorbid dissociative disorder should alert clinicians for a more chronic and severe psychopathology among patients with conversion disorder.

Reprints: Istanbul Tip Fakultesi Psikiyatri Klinigi, 34390 Capa, Istanbul, Turkey. Email: vsar@istanbul.edu.tr

Savitz, J., Solms, M., Pietersen, E., Ramesar, R., & Flor-Henry, P. (2004). Dissociative identity disorder associated with mania and change in handedness. *Cognitive & Behavioral Neurology, 17*(4), 233-7.

A case of co-occurring bipolar disorder and dissociative identity disorder (DID) is presented in which the "switch" in personality coincided with manic or hypomanic symptoms and was associated with a change in handedness. A parallel between the "personality" shifts that characterize DID and the mood fluctuations that underlie bipolar disorder is drawn, suggesting some nosological overlap between the two disorders. The possibility that these two psychiatric conditions share a similar neurophysiological architecture is also raised.

Reprints: MRC/UCT Human Genetics Research Unit, University of Cape Town Medical School, Observatory, 7925, South Africa. Email: js@cormack.uct.ac.za

Simeon, D., Greenberg, J., Nelson, D., Schmeidler, J., & Hollander, E. (2005). Dissociation and posttraumatic stress 1 year after the World Trade Center disaster: Follow-up of a longitudinal survey. *Journal of Clinical Psychiatry, 66*(2), 231-7.

The authors conducted a 1-year follow-up of an original mail survey of early reactions to the World Trade Center disaster to determine whether dissociative versus posttraumatic symptoms at follow-up could be dissected on the basis of early reactions. Of the 75 subjects originally surveyed, 58 (77%) responded. The survey included measures of dissociation (Dissociative Experiences Scale, Cambridge Depersonalization Scale, Clinician-Administered Dissociative States Scale), post-traumatic stress (Impact of Event Scale-Revised), social support (Interpersonal Support Evaluation List-short form), and a life quality measure (Quality of Life Enjoyment and Satisfaction Questionnaire-short form). Results revealed that exposure was not associated with dissociation or posttraumatic stress at follow-up. Rather, baseline dissociation was the strongest predictor of outcome dissociation while baseline posttraumatic stress was the strongest predictor of outcome posttraumatic stress. Of 4 peritraumatic distress factors generated in the original survey, "loss of control" and "guilt/shame" were significantly related to dissociation and posttraumatic stress at outcome, while "helplessness/anger" was only associated with posttraumatic stress at outcome. Lesser improvement in posttraumatic stress over the first year was significantly related to less social support and greater comorbid dissociation. Interim social support was associated with better life quality and fewer symptoms at outcome. These results provide evidence for partly independent pathways toward dissociation versus posttraumatic stress 1 year after the disaster. Feelings of guilt and shame, and persistent dissociation, were poor prognostic factors, while social support had a powerful ameliorating influence.

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Talbot, J. A., Talbot, N. L., & Tu, X. (2004). Shame-proneness as a diathesis for dissociation in women with histories of childhood sexual abuse. *Journal of Traumatic Stress, 17*(5), 445-8.

This study examined whether shame-proneness is associated with dissociation among abused women. Participants were 99 hospitalized women with and without reported histories of childhood sexual abuse. Hypotheses were that childhood sexual abuse and shame-proneness would each be associated with dissociation, and that the relationship between sexual abuse and dissociation would be greater among women with higher shame-proneness. Multiple regression analysis indicated that shame-proneness was independently related to dissociation, but childhood sexual abuse was not. As predicted, the combination of shame-proneness and childhood sexual abuse was associated with dissociation.

Reprints: Department of Psychiatry, University of Rochester School of Medicine and Dentistry, Rochester, New York, USA. Email: Jean_Talbot@URMC.Rochester.Edu

Woller, W. (2005). [Trauma repetition and revictimization following physical and sexual abuse] [Article in German]. *Fortschritte der Neurologie-Psychiatrie, 73*(2), 83-90.

The tendency of victims of physical or sexual childhood abuse to become revictimized in later life has well been documented empirically. The aim of this paper was to summarize perspectives from psychodynamic theory, attachment theory,

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and posttraumatic stress research to explain revictimization phenomena. Within the psychodynamic framework, an ego-psychological view conceives trauma repetition as an attempt to master traumatic experience, while in the object relations perspective, revictimization is explained by the influence of traumatic introjects. Negative cognitions of being worthless, bad and guilty can endorse the conviction that abuse is justified and reduce the capacity of self-care. Negative learning experiences from traumatic helplessness and powerlessness account for low self-efficacy expectations and prevent the establishment of self-boundaries. Trauma repetition can also be understood as an enactment in the service of affect regulation. Research in the field of attachment theory identified attachment styles predisposing to revictimization. Research dealing with posttraumatic stress disorder emphasizes the importance of traumatic affects recurring in daily life and, consequently, the tendency of abuse victims to actively produce dangerous situations in order to cope with these affects. Dissociation may play a role in the individual missing warning signals of impending traumatization. For therapeutically addressing revictimization, a detailed analysis of underlying phenomena is required.

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Zimmermann, P., Hahne, H.H., Biesold, K.H., & Lanczik, M. (2005). [Psychogenic Disorders in German soldiers during World War I and II] [Article in German]. *Fortschritte der Neurologie-Psychiatrie, 73*(2), 91-101.

In the First and Second World War German soldiers frequently suffered from psychogenic disorders. In the First World War dissociative disorders dominated the clinical impression ("shell shock"), in the Second World War they were replaced by somatoform and psychosomatic diseases. This paper examines the reason for this change. According to trauma research, dissociative and somatoform disorders can emerge in a close relation to a Posttraumatic Stress Disorder. The choice of symptoms depends on personality traits of the victim, but also on specific factors that characterize the situation in which the trauma appears. The mixture of pathogenetic and protective influences includes e.g. the possibility of flight- or fight reactions, feelings of trauma-associated guilt and group cohesion in the military unit. These factors can be useful to help explain the change of symptoms between both wars. In addition the analysis of situational conditions in former wars can give hints to actual planning and prophylaxis strategies in modern military psychiatry, that has to adjust to very different military operation fields.

Reprints: Abteilung Psychiatrie und Psychotherapie des Bundeswehrkrankenhauses, Berlin.

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