We are now into the final quarter of the year. The Board of Directors has reviewed our Strategic Plan and budget for next year, to keep us on track. Thomas Carlton, our financial wizard, continues in his role both teaching fiscal comprehension and keeping us financially responsible. I am gathering up reports from all of our committees to be assessed by the Board this month. This is the infrastructure that gives us stability and the ability to move forward with confidence.

Three days in August were spent sitting in with the Certificate Program Committee. It was intense and rewarding to see the program coming into fruition. Thirty-two presentations at this year’s conference have been approved for credit toward the certificate!—what a thrill to see such a level of excellence among us. Our collective wisdom shines! The Core Areas of Knowledge © and the distribution of credits are now on our website. The credits are now synchronized with the Core Areas for these conference presentations and the Professional Training Program courses. So, do take advantage of our continuing education programs, both at the conference and in our courses. Learning is what keeps us vibrant and growing professionally.

As I wind down this year as president, I am very pleased to think about our accomplishments: a new website, participation in developing trauma competencies (and showing off the work already done by ISSTD), growing cohesion of the Board of Directors, revised and updated curricula for the Professional Training Program, coordination of the MEMO and ISSTD News, a renewed commitment to teaching by so many, evidence of fiscal responsibility by starting to pay back the Development Fund and work on a reserve, and coordination and refreshing dialogue everywhere. I may be a catalyst, but the energy is evident everywhere. There is a new energy to speak up and share, to disagree respectfully, to work through difficult issues, to maintain our foundation and build on it, to change and create. It has been an honor to serve as president this year, and I know that I will treasure the experience in the years to come.

Our Town Hall Meeting this year will ask the question: “What do you want for the future of ISSTD?” This is YOUR society, YOUR professional organization. So, put your creative, thinking cap on and come prepared with YOUR great ideas. Together, we give voice to OUR vision!
Hello ISSTD Members,

This month completes my first year as the ISSTD Treasurer. It has been a fairly smooth year, busy but smooth. Financially we are very stable. Conference registration revenue is on track in comparison with previous years. This year we have a lot in store for our 30th Anniversary, including a haunted pub tour hosted by the student and emerging professional committee, all are welcomed. The link to registration is on the web site.

A major area of focus needs to be membership retention and expansion. As with all organizations, growth and expansion is important. I suggest you recommend our society membership to fellow colleagues. Feel free contact us for information on the many benefits of being a member.

Our Annual Audit has confirmed that we have had a slow, but steady increase in our financial bottom line; this has a lot to do with wise spending. The financial decisions that we have made in the last year have helped in further creating financial stability. We are finally paying back the Development Fund, this payback is a testament to our improved financial stability.

Currently all of our outstanding bills/payments have been paid. We are looking into what is currently happening with various accounts, funds and investments. We are looking into all of these accounts to see if they are advantageous or if there are things that can be done that will improve our financial stability. We are also beginning to examining our other funds and get them running as smoothly as the Caul Fund. If anyone is interested in being part of a fund committee, please contact me.

We look forward to continually refining and increasing our activities to ensure our financial strength.

From the ISSTD Finance Committee,
Thank you.
Christine Forner, MSW, RSW
Treasurer

For many of us, the annual conference is the highlight of the year for ISSTD. We meet friends and colleagues, learn the latest about our field, network, and have fun. It’s clear that organizing a conference takes a lot of work, but few people know the extent of the work involved. The Conference Committee plans conferences three years in advance — that’s what it takes to schedule the best plenary speakers, find the best site, and decide the most appropriate theme.

Cost and location come into play in deciding where to hold the conference. ISSTD needs a venue large enough to hold meetings of the entire group, space for vendors, and sufficient smaller rooms for workshops, paper presentations, and symposiums. The site needs to be attractive, near public transportation, and be willing to limit the cost of rooms so that our attendees can afford to come and to stay.

ISSTD holds its conferences alternately on the East Coast and West Coast of the U.S. At the East Coast meeting, we’re able to connect with more of our ESTD colleagues. On the West Coast, our Pacific Rim members are able to attend in larger numbers. We’ve coordinated our meetings to have our East Coast meetings on the years between ESTD meetings, for the benefit of both organizations.

Once the site and time are chosen, the Conference Committee and our management team set up the Call for Papers. Abstracts are submitted and are sent out to people chosen by our Scientific Committee for review. Those presentations that are accepted are then sent back to the Conference Committee where some of our hardest working people (Kevin and Thérèse) have the job of putting all those workshops, papers, plenaries, etc., into a schedule that works for everyone, a daunting job. All of this goes then goes onto the website, with constant updates.

While you’re at the conference, watch Thérèse (our Executive Director), Jenn and Liz (also from AMG) and all of our Conference Committee members continually working to make your experience as good as possible.

After the conference, the work continues. Bills are paid, issues raised during the conference are handled, CEU’s are monitored, input from the membership during the Town Hall is sent to whomever can best respond, and volunteer names are distributed to committee chairs. The conference evaluations are read, and help improve the next year’s conference.
Your conference committee continues to work to fine tune and add to the educational opportunities. We have added another all day Pre-Conference Institute on understanding and using the SCID-DD. Thursday 14 November, we are honored to have Dr. Charles Rousell presenting How Evidenced Based Diagnosis of the Dissociative Disorders Using the SCID-D Informs Clinical Treatment: Video Case Presentations of Ego State Therapy for Complex Dissociative Disorders.

In a previous edition of our newsletter, ISSTD President Joan Turkus shared exciting news about the new Certificate Program. As the caliber of courses submitted and accepted improves, this year’s conference now has 32 different classes selected as part of the Certificate curriculum. Most of the Pre-Conference Institutes and the Monday afternoon Advanced Seminars as well as many workshops and forums are earmarked with a Key symbol. Look for them in the Conference Program.

We are closer to developing a Child and Adolescent track and have many presentations geared to working with children. Look for them in our program identified with a smiley face symbol.

**ISSTD’s 30th BIRTHDAY BASH**

Our conference in Baltimore marks the 30th gathering of our professional community and we’ve decided to throw a party. Of course, YOU are invited.

Sunday evening, 17 November, we’re having ISSTD’s 30th birthday party at the Hilton Baltimore. To make the party a real blow-out, we’re bringing in Dr. Blues himself. ISSTD’s own Rich Loewenstein will bring a band of musicians to help us rock the joint.

There will cake and presents, as well as the opportunity to unwind with colleagues from around the world. We will be giving away a hotel stay at the Lake Buena Vista Hotel in Orlando Florida to be used in conjunction with our 2015 Conference. After several days of intense learning, we encourage you to take time to celebrate and relax to recharge yourself. Please join us for a great time and a lot of fun.

**TRAVEL TIPS**

Baltimore is a very accessible and travel friendly town. Guests arriving at the Baltimore Washington International Thurgood Marshall Airport can take a Light Rail train directly from the airport to the Hilton Baltimore Hotel. For $1.60 (USD), you ride the Hunt Valley train directly to the Pratt Street Light Rail stop. For more information, go to mta.maryland.gov/light-rail. You can also check out our website to help make travel arrangements and hotel reservations.

See You in Baltimore!

Kevin Connors, MA, MFT
Most cases of child abuse can be considered in fact cases of transgenerational dysregulation. It is unrealistic to expect parents who haven’t been taught kindly self-regulation themselves to teach it to their children. Environment and culture are also involved: in some environments it is important for survival to react quickly, to be wary, and to expect danger and hostility. The normative values embodied in most child therapy assume a fairly benign environment, which parents may feel is a dangerous assumption for their children to make.

When and how does a child learn self-regulation? When an infant is crying, it doesn’t have the cortical resources to tell itself “there, there, everything will be all right.” Basic self-regulation is learned pre-verbally, somatically and emotionally, from thousands of repeated micro-interactions. It is shaped by the child’s developmental age, physiology, temperament, prenatal experience, and the parent’s attachment styles, which can be seen as transmitted patterns of self-regulation. The child internalizes how she is regulated by the caregiver. An example that is both funny and sad comes from my work with dysregulated parents who are alarmed because their toddler is hitting herself. The parents are distressed at the child’s self-harm, while seeing no connection between what they are doing to the child and what she is doing to herself.

If the parents are untreated survivors of Developmental Trauma Disorder (DTD), they are likely to have difficulties with regulation in many domains: somatic, integrative (dissociation), affective, behavioral, interpersonal (attachment) and cognitive, putting the child at risk in these domains. Because regulation is originally learned on the preverbal level, nonverbal work augments more cortically-oriented interventions. This nonverbal work may include rhythmic somatic experiences such as breathing. Many trauma survivors have immobilized diaphragms and hold their breath, so that they have to breathe out before they can breathe in. A child may not have experienced a household that is both predictable and flexible, with good transitions and regular mealtimes to develop self-regulation. Many nonverbal aspects of the therapeutic encounter constitute a reparative intervention for a chaotic upbringing (e.g. the physical environment, the management of boundaries and transitions, the person of the therapist). This creates opportunities for the client to internalize new modes of regulation.

Frances Doughty, MFT, works with low-income caregiver-child dyads at an agency in Richmond, CA and sees individual adults and children in private practice. She is also an active member of the Child and Adolescent Committee of ISSTD’s Child and Adolescent SIG.

Further reading:
Posttraumatic stress disorder (PTSD) is a prevalent psychiatric diagnosis among veterans and has high comorbidity with other medical and psychiatric conditions. This article reviews the pharmacotherapy recommendations from the 2010 revised Department of Veterans Affairs/Department of Defense Clinical Practice Guideline (CPG) for PTSD and provides practical PTSD treatment recommendations for clinicians. While evidence-based, trauma-focused psychotherapy is the preferred treatment for PTSD, pharmacotherapy is also an important treatment option. First-line pharmacotherapy agents include selective serotonin reuptake inhibitors and the selective serotonin-norepinephrine reuptake inhibitor venlafaxine. Second-line agents have less evidence for their usefulness in PTSD and carry a potentially greater side effect burden. They include nefazodone, mirtazapine, tricyclic antidepressants, and monoamine oxidase inhibitors. Prazosin is beneficial for nightmares. Benzodiazepines and antipsychotics, either as monotherapy or used adjunctively, are not recommended in the treatment of PTSD. Treating co-occurring disorders, such as major depressive disorder, substance use disorders, and traumatic brain injury, is essential in maximizing treatment outcomes in PTSD. The CPG provides evidence-based treatment recommendations for treating PTSD with and without such co-occurring disorders.


BACKGROUND: After 23 years of the end of the Iran-Iraq war, the country is left with many patients with chronic posttraumatic stress disorder (PTSD) who need close psychiatric services and are in need for recurrent hospitalization. So far, there are no reports of the rivastigmine use in PTSD patients. We report dramatic reduction of symptoms in 3 veterans with chronic PTSD, after rivastigmine augmentation.

CASE PRESENTATION: This report describes the efficacy of rivastigmine as an add-on to standard treatment of 3 Iranian male veterans with chronic PTSD (aged 52, 46, and 45 years) with severe active symptoms in all 3 dimensions of the disorder. Although they had gone through many approved drug treatments (selective serotonin reuptake inhibitors, tricyclic antidepressants, mood stabilizers, antipsychotics, benzodiazepines, β-blockers, and so on), from the beginning of the disorder, their recovery remained poor (PTSD Checklist-Military Version [PCL-M] scores were 67, 71, and 73 before rivastigmine add-on). Rivastigmine was added to the ongoing therapeutic regimens of the patients for 6 months. Evaluating their condition with PCL-M after 1 and 6 months of treatment showed a significant improvement in patients with PTSD (PCL-M scores were 37, 40, and 47 and dropped to 30, 27, and 31, respectively). Hyperarousal symptoms of PTSD in patients are noted to be the most improved. The rivastigmine add-on experience did not report any adverse effects.

CONCLUSIONS: The present study showed that rivastigmine is an effective and safe add-on to treatment of patients with chronic PTSD. This effect could be due to improved cognitive status or cholinergic-adrenergic balance adjustment in patients.


Posttraumatic stress disorder (PTSD) is a prevalent psychiatric diagnosis among veterans and has high comorbidity with other medical and psychiatric conditions. This article reviews the pharmacotherapy recommendations from the 2010 revised Department of Veterans Affairs/Department of Defense Clinical Practice Guideline (CPG) for PTSD and provides practical PTSD treatment recommendations for clinicians. While evidence-based, trauma-focused psychotherapy is the preferred treatment for PTSD, pharmacotherapy is also an important treatment option. First-line pharmacotherapy agents include selective serotonin reuptake inhibitors and the selective serotonin-norepinephrine reuptake inhibitor venlafaxine. Second-line agents have less evidence for their usefulness in PTSD and carry a potentially greater side effect burden. They include nefazodone, mirtazapine, tricyclic antidepressants, and monoamine oxidase inhibitors. Prazosin is beneficial for nightmares. Benzodiazepines and antipsychotics, either as monotherapy or used adjunctively, are not recommended in the treatment of PTSD. Treating co-occurring disorders, such as major depressive disorder, substance use disorders, and traumatic brain injury, is essential in maximizing treatment outcomes in PTSD. The CPG provides evidence-based treatment recommendations for treating PTSD with and without such co-occurring disorders.


Post-traumatic stress disorder (PTSD) is a psychiatric disorder of significant prevalence and morbidity, whose pathogenesis relies on paradoxical changes of emotional memory processing. An ideal treatment would be a drug able to block the pathological over-consolidation and continuous retrieval of the traumatic event, while enhancing its extinction and reducing the anxiety symptoms. While the latter benefit from

If you have published an article or know of an article that you think should be included in this column, please send the complete citation and, if possible, reprint address and email, to Dan Nothmann, Psy.D., 66 Painter’s Mill Road, Ste. 204, Owings Mills, MD 21117, USA, or email it to DNothmann@Comcast.net. Copies of complete articles are especially welcome.
antidepressant medications, no drug is available to control the cognitive symptomatology. Endocannabinoids regulate affective states and participate in memory consolidation, retrieval, and extinction. Clinical findings showing a relationship between cannabis use and PTSD, as well as changes in endocannabinoid activity in PTSD patients, further suggest the existence of a link between endocannabinoids and maladaptive brain changes after trauma exposure. Along these lines, we suggest that endocannabinoid degradation inhibitors may be an ideal therapeutic approach to simultaneously treat the emotional and cognitive features of PTSD, avoiding the unwanted psychotropic effects of compounds directly binding cannabinoid receptors.


Prolonged exposure (PE) therapy is considered a gold standard protocol for the treatment of PTSD, and it is associated with large treatment effect sizes in combat veteran samples. However, considering high rates of PTSD in the present veteran population, ongoing research work is important toward improving treatment efficiency by decreasing time to symptom amelioration and increasing the amount of symptom amelioration. The proposed research aims to enhance exposure therapy outcomes for veterans with PTSD via combination treatment with PE and yohimbine hydrochloride (HCL), an alpha-2 adrenergic receptor antagonist. The proposed investigation entails a randomized, placebo-controlled trial investigating the effect of a single administration of yohimbine HCL (paired with the first session of imaginal exposure) on outcome of PE in 40 veterans with PTSD. An additional goal is to establish a pragmatic method of tracking psychophysiological measures over the course of therapy for incorporation into future clinical psychotherapy trials. Thus, in addition to traditional self- and clinician-reported psychological outcomes, heart rate and skin conductance reactivity will be measured during a standard trauma-specific imagery task before, during, and after PE treatment. We will further investigate whether changes in psychophysiological measures predict changes in patient- and clinician-reported outcome measures.


Ketamine has been used in anesthesia for many years and in various environments with an acceptable safety margin. The side effects of hallucinations and paranoid thoughts need to be overcome for acceptance of ketamine infusion in mainstream psychiatry. In this case report, the anesthesia department was consulted because of familiarity with the medication and the ability to modulate unacceptable side effects with its use as is done in monitored anesthesia care. It is proposed that ketamine has potential for treatment of major depression associated with posttraumatic stress disorder (PTSD) in combat veterans. This patient, who had debilitating and treatment-resistant major depression and PTSD, was treated by intravenous infusion of ketamine and experienced substantial short-term resolution of symptoms.
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Welcome to Members’ Clinical Corner—a feature and benefit of membership in ISSTD. We bring to you, a featured past theoretical, empirical, or clinical article from the Journal of Trauma & Dissociation or our organization’s first journal, Dissociation, accompanied by a commentary prepared by an expert clinician in ISSTD. This month’s commentary was prepared by Serge Goffinet, PhD.

Happy reading!

Member’s Clinical Corner
Andreas L addis, MD - Clinical Corner Editor

Eating Disorders and Dissociative Processes
Serge Goffinet, MD.


From the abstract: This study investigated the relationship between trauma, dissociative experiences, and eating psychopathology in a group of eating disorder patients. Significant differences were found in the prevalence of traumatic experiences between eating disorder patients and control subjects, but not between eating disorder and schizophrenic patients. The highest total DIS-Q scores were detected in bulimia nervosa and anorexia nervosa binge eating/purging type patients; the lowest DIS-Q scores were found in patients with binge eating disorder, schizophrenia, and controls. Eating disorder patients, in comparison with schizophrenic patients, reported significantly higher scores in identity confusion, loss of control, and absorption. However, the only dissociative features which seem to link trauma, dissociation, and eating disorders are identity confusion and loss of control, since absorption is not sensitive to the presence/absence of trauma.

Commentary: I would like to discuss what is new in our understanding of dissociation and eating disorders (ED) since the study by Dalle Grave et al., one of the first to examine this relationship. Clinicians have compared the acts of binge eating and purging to dissociative experiences. There are at least two distinct links between dissociation and ED.

First, eating disorders (bulimia and anorexia) are essentially processes of emotional avoidance, which may evolve toward complete emotional dissociation.

Second, the ability to experience dissociation may be related to the high hypnotizability found in bulimic patients.

Eating disordered behavior essentially is a coping mechanism, usually compensating for low self-esteem (Strober, 1987). These patients have problems with their overall self-image, excessive concern over weight and shape, and globally negative attitudes about their self-control and discipline. Using measures of dissociation (DIS-Q; Vanderlinden, 1993) and self-esteem (Rosenberg self-esteem-scale, Rosenberg, 1965), a recent publication found that low self esteem and dissociation correlated with a negative outcome after a treatment program for eating disorders (La Mela et al., 2013). As traumatologists, we presume that trauma and dissociation due to early-life trauma also lead to poor self-esteem. Attachment, the emotional bond formed between an infant and its primary caretaker, profoundly influences both the structure and function of the developing infant’s brain. Insecure attachment, caused by abuse, neglect or emotional unavailability on the part of the caretaker, influences the developing brain which, in turn, affects future interactions with others. Insecure attachment involves a representation of the self as not lovable, leading to low self-esteem…full text at ISSTD Members Clinical Corner.

Serge Goffinet, M.D. works in Brussels, Belgium in both private practice and in a psychiatric hospital setting with an interest in dissociative and eating disorders. Serge also serves as the International Director on the ISSTD Board of Directors and is an active member of the European Society for Trauma & Dissociation (ESTD).
Announcements

Elections and Bylaws Change
An important e-mail is being sent to all members to vote for the upcoming slate of board candidates and to review and vote on important board recommended changes to the current Bylaws. Please participate! Voting is a privilege of membership! Polls Close October 15, 2013. You may log into the Member’s Only Corner to access the information and cast your vote.

Annual Conference Deadlines

Online Registration will close October 15. Click here to register today!

Thereafter, please register on site.

Take advantage of the special conference attendee room rate at the Hilton Baltimore of $189 single/double occupancy. Rates are available to ISSTD conference attendees booked by October 13, 2013! Click here to make your room reservation today!

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