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From the President



Catherine C. Classen
PhD, CPsych

Building a Mentorship Program

In my final presidential column, I'd like to return full circle to an interest I had when I first ran for the Board four years ago. As part of my platform in running for the Board, I proposed that ISSTD develop a mentorship program. Fortunately, the idea of developing a mentorship program has been embraced by the Board and is now reflected in our strategic plan. In this column I will define what is meant

by mentorship, discuss why we should consider developing such a program, describe how it might be structured and run, and outline some of its benefits. I will conclude with a final reflection on my year as president.

What is mentorship?

Mentorship is a relationship in which one professional contributes to the professional development of another. This is a dynamic relationship in which the mentor helps a more junior person, the mentee or protégé, grow and advance as a professional. However, it is more than likely that both mentor and mentee will benefit by engaging in this relationship.

Mentoring can come in many forms and with a variety of goals. It can involve mentoring students, professionals just entering the field, or those who are midway in their career. It can be circumscribed or broad in its focus. Whatever its focus, the common theme is to have a professional or trainee benefit from a mentor's store of knowledge and from his or her professional guidance.

Is there a need for a mentoring program?

Working as a clinician in the field of trauma and dissociative disorders is not for the faint of heart. By definition, trauma is overwhelming and working with its effects is often overwhelming to the clinician as well. This is especially so for those who are new to the field. There are many challenges to working with trauma. The clinician must learn to deal with crises, flashbacks, reenactments, shifting identity states, as well as intense

transference and countertransference. Treatment for dissociative disorders or complex PTSD are typically long and arduous. There are no neat and simple treatment protocols and few, if any, clinicians receive formal training to do this work. Many of our colleagues are skeptical about these disorders and thus clinicians working in this field can feel quite isolated, unsupported, and even lost at sea. The highly active listservs, DISSOC and ISSDWorld, are an indication of the need and thirst for information, connection and support. These listservs provide a much needed service and are often an informal source of mentoring.

In my presidential address at this year's conference, I made a plea for more scientifically rigorous treatment outcome studies. Our field lags far behind in terms of outcome studies on dissociative disorders or complex PTSD. This was evident when I simply counted the number of published outcome reports on dissociative disorders and complex PTSD compared to outcome research on PTSD, borderline personality disorder, or chronic traumatization. With the ever growing emphasis on evidence-based treatment, the legitimacy of our field is increasingly put in jeopardy as other fields amass scientifically sound evidence for their treatments while we do not. Conducting outcome research on dissociative disorders and complex PTSD is difficult for a variety of reasons, not the least of which is that there are few researchers who are committed to this field. At the same time, we have a wealth of clinicians many of whom are eager to participate in gathering evidence for effective treatment. A mentoring program would provide a vehicle for researchers to mentor clinicians who want to conduct scientifically rigorous single case studies or who want guidance in writing up their cases for publication. It would also be valuable for students who are interested in conducting research in our field. ISSTD must find



ways to nurture research and this could be a useful mechanism.

Although I believe that a mentorship program would be valuable to our Society, the first step in developing a mentorship program is to assess whether there is sufficient need and interest among our members. Thus, the membership must be polled so that you can tell us whether you are interested in being either a mentor or a mentee. It will also be important to know the scope of mentoring that members are seeking and what potential mentors would expect in return for becoming a mentor. If you're wondering whether you would be interested in becoming a mentor, go to the following link where you will find "Six reasons to become a mentor" by Dr. Linda Phillips-Jones (http://www.mentoringgroup.com/html/articles/mentor_32.htm).

How would a mentorship program be structured and run?

Let's consider what a mentorship program might look like. How it is actually structured, however, will need to be hammered out by a task force and approved by the Board. Nevertheless, here are some initial thoughts.

A successful mentoring relationship is one that is collaborative and structured, with the mentee providing an initial tentative set of goals that are then refined with the aid of the mentor. With the guidance of the mentor, the mentee should also establish a plan on how to reach these goals. This facilitates the setting of an agenda, which again is up to the mentee to monitor. This process allows the program to be individualized according to the needs of the mentee and, by engaging the mentor in refining the goals and plan, ensures that it is a realistic set of expectations. Along with helping the mentee refine the goals and agenda, the role of the mentor is to listen attentively and to offer thought provoking questions, suggestions, and challenges to meet the needs and goals of the mentee.

A clearly defined structure to the mentoring relationship is key. The relationship should be time-limited and this should be made clear from the outset. The length of the relationship could be anywhere from three months to a year and there could also be the option to renew the mentoring contract if both mentor and mentee agree. The frequency and amount of contact should be carefully defined. For instance, it might be one hour every two weeks or half an hour each week or every other week. This could occur face to face or over the phone. Alternatively, the relationship might be conducted via email with constraints around the frequency of contact. There should be concrete markers for success which would be helpful for both the mentee and mentor and there should be an evaluation process so that the program can be assessed.

While the program consists of the mentors and mentees, it also includes the volunteers who manage the program. Program coordinators are needed to secure the commitment of mentors and mentees, to prepare both mentors and mentees for their respective roles, and to ensure proper matches between mentors and mentees. The program coordinators would also ensure that there is training and guidance for the mentors in order to help them provide an optimal mentoring experience.

A major challenge in a mentorship program is matching mentors with mentees. Both mentors and mentees would be required to complete application forms to ensure their appropriateness for the program. One model for matching would be to have the pro-

gram coordinators make the match based on the needs of the mentees and the skills of the mentors. Another model would be to allow the mentors to review the pool of mentees as well as having the mentees review the pool of mentors. In each case, identifying information would be removed. The mentors and mentees would indicate their top three choices and the program coordinators would consolidate these choices and determine the final match. Another model would be to allow mentees to approach mentors directly to request a mentorship relationship. No matter which model is used, key to the success of the process is that there are a sufficient number of mentors available to match with mentees.

What would the program cost?

The cost for a program of this type should not be prohibitive. Costs would consist of the production of manuals, application forms, postage, staff time, phone and fax. The cost would be somewhere around \$4,000 to start it up and much less to maintain. A careful analysis of cost would need to be conducted before we decide to proceed. This program will also depend on a strong volunteer effort.

How would it benefit our Society?

While a successful mentoring program is helpful for the individuals directly involved, it is also beneficial to our Society and the field in general. If participation is restricted to ISSTD members, a successful mentoring program will have the potential to attract and retain members. It will also facilitate cross-fertilization and networking opportunities among our members. It could become a valuable mechanism for leadership development within our Society. Most importantly, it will facilitate increased knowledge, best practice, and build research capacity within our field.

I hope this brief description has given you a flavor for what a mentorship program could offer ISSTD and its members. Whether or not we proceed with such a program will depend on the interest of you, our members. Be sure to respond to the survey when it is posted and let us know whether you would like to participate as either a mentor or a mentee. You might even decide that you would like to participate in both capacities. Please give it careful consideration. If you think you have something to offer no matter how vast or circumscribed your knowledge and experience, consider putting your name forward as a mentor. Here is your opportunity to help shape the future of our field.

Closing reflections on my year as president

Before I close, I'd like to reflect on my year as president. The year has flown, as I was warned it would. It is almost as though I took one deep breath and a year later have come up for air. This year presented many challenges and opportunities, both expected and unexpected. Important accomplishments were made. Our new, award winning website and our hugely successful conference were definitely the highlights of the year. The discovery of the true state of our Society's finances and navigating a difficult Business Meeting at the conference were by far the low points. Personally I have learned a great deal from this adventure and like to think that it has enabled me to grow in ways I might not have otherwise. It has been a privilege to serve as your President in 2007 and I thank you for giving me this great honor.

Who's Who in ISSTD: Communication Standards Committee

Tara L. Williams, PhD
Editor

The mission of the Communication Standards Committee (CSC) is to review and approve materials produced by the Education Committee and other task forces of the ISSTD before these materials are published or posted on the website. The purpose of review is to evaluate materials in terms of their readability, clinical and scientific validity, and appropriateness for intended audiences, such as mental health professionals, educators or the public.



Theresa Albin
Chicago

● **Theresa Albin, LCSW**, is a diplomate in clinical social work and has been a member of ISSTD for 24 years. She presents at conferences and publishes articles, including one of the first regarding dissociation in early childhood. She has educated individuals regarding the diagnosis and treatment of dissociative disorders and trauma-related syndromes in a variety of clinical settings. During her 32-year career, she has treated adults and children, as well as provided supervision, interdisciplinary training, and state-wide consultation. In addition to her current private practice, she has been the clinical director of adult outpatient and emergency services programs.

● **Lisa Butler, PhD** was profiled in the Sept-Oct 07 newsletter as a member of the David Caul Grant Committee.

● **Kevin Connors, MFT**, is a licensed Marriage & Family Therapist in private practice in Long Beach, California. A member of ISSTD since 1986, he was twice president of the Orange County Chapter of the ISSD. A founding member of the Western Clinical Conference on Trauma and Dissociation, he served as chair of the conference committee from 1990 to 1997. He is liaison between the ISSTD and the Institute on Violence, Abuse and Trauma.



Kevin Connors
Long Beach, CA

He is currently exploring the role of shame and powerlessness in dissociative disorders and is investigating the prevalence of dissociation among both victims and perpetrators of domestic violence.



Esther Giller
Baltimore

● **Esther Giller** is President of Sidran Institute, www.sidran.org, a nonprofit organization that helps people understand, recover from, and provide care for psychological trauma, extreme stress, and dissociative disorders. She

specializes in forging collaborative multidisciplinary responses to traumatized individuals and families in settings such as state mental health systems, jails, urban neighborhoods, and faith communities. Under her direction, Sidran provides education and publications for professionals and lay persons. Ms. Giller has authored multiple articles and co-edited two books, *MPD from the Inside Out* and *Risking Connection® in Faith Communities*. She has been quoted about trauma in *Time*, *Newsweek*, *NPR*, *MSNBC*, *CBS* and *HealthWatch*, among others.



Andreas Laddis
Massachusetts

● **Andreas Laddis, MD**, chair of the communication standards committee and Director on the Executive Council, is a psychiatrist working in community mental health care in Massachusetts. He was raised and educated in Greece, and trained in psychiatry at Sheppard Pratt Hospital. Dr. Laddis has always worked in government-sponsored mental health

agencies, promoting effective treatment for posttraumatic disorders in community mental health centers. Dr. Laddis' clinical specialty is providing psychotherapy for posttraumatic and personality disorders. Academically he strives to distinguish posttraumatic disorders from other mental disorders. He has done some research regarding differential diagnosis as well as validation of the efficacy of his Cape Cod Model of psychotherapy.

● **Robert B. Slater, LCSW-R**, is a graduate of Marywood University in Scranton, PA., and is a member of the Alpha Lambda National Honor Society. He has worked in residential, school, and private practice settings in upstate New York. He founded the group practice Copeland Ave Associates in 2004. His practice includes work with adolescents, adults, and couples. He has presented in several school districts regarding the impact of neglect and trauma in the classroom environment. In addition to his involvement with ISSTD, he is also a member of ISTSS, NASW, and EMDRIA. He is a certified EMDR Therapist.



Robert Slater
Homer, NY

Critical Issues

Developmental Trauma Disorder: A New Diagnosis for Children Affected by Complex Trauma

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Recently, there have been calls for a new child diagnosis that will accurately describe the pervasive developmental effects of “complex trauma” in childhood. The American Psychiatric Association newsletter (Moran, 2007) and the American Psychological Association Monitor (DeAngelis, 2007) have both featured articles summarizing experts’ views on the topic. Bessel van der Kolk (2005) published the rationale for and a broad overview of a proposed diagnosis, Developmental Trauma Disorder (DTD), which was also a focus of his Pierre Janet Memorial Lecture at ISST-D’s Annual Meeting last year. Pynoos, Steinberg and Wraith (1995) proposed a developmental model of child traumatic stress that emphasizes not only complex adaptations to trauma, but also the ways in which trauma may interfere with development and increase risk for psychopathology. Robert Pynoos (personal communication, October 18, 2007) points out that “the interactions of developmental interferences, unresolved chronic traumatic reactions, and chronic adaptations to trauma are serious, often devastating” and that “repeated or serial trauma often leaves no time for recovery and continues to affect even latter developmental periods.” While the need for a diagnosis that can account for the developmental impact of and adaptations to complex trauma is evident to many, there is as yet no clear consensus, even among child trauma experts, about what such a diagnosis ought to include. Do we need a new diagnosis for children with complex posttraumatic presentations? In this article I discuss a few of the reasons that the answer to this question should be a resounding and unanimous yes.

Reason #1: Accurate diagnosis is essential to appropriate intervention.

Gabriela (age 16) was referred to our Children’s Advocacy Center (CAC) by a neighboring police department after disclosing chronic sexual abuse by a maternal

cousin from age 6 to 10. This was not Gabriela’s first time at our CAC. Six years earlier, while the abuse by her cousin was still occurring, Gabriela had participated in an investigative interview during which she disclosed isolated incidents of sexual abuse by paternal relatives who were ultimately criminally charged and convicted. Following that interview, Gabriela was assessed and diagnosed with Posttraumatic Stress Disorder. She then participated in an apparently successful 5-month abuse-focused psychotherapy, during which the abuse by her cousin remained secret. When Gabriela returned to the CAC at 16, she appeared to have simple PTSD, except for the fact that she reported having no memory of the previous treatment.

In therapy, Gabriela, an academic “overachiever,” identified “different parts” of her self, which she labeled “Everyday self,” “Angry self,” “Happy self,” and “Sad/Depressed self.” She had discussions with her therapist about sex, dating, boys, and the fact that she was not interested in becoming sexually active. In a subsequent session, she mentioned a boyfriend with whom she had had sex. Gabriela had no memory of her previous statements to the therapist about not wanting to have sex and was surprised that her therapist did not know about her boyfriend and had no memory of her previous statements to the therapist about not wanting to have sex. Gabriela’s treatment included trauma narrative work and also included a major focus on the identification, acceptance, and integration of the dissociated aspects of Gabriela’s self and experience.

Gabriela’s clinical presentation is likely a familiar one to readers of this newsletter, many of whom treat the adult Gabrielas of the world, after their symptoms have had years to develop, solidify, and pervade every aspect of their lives. The more we learn about trauma and dissociation, the more we understand how Dissociative Disorders and

other Complex Posttraumatic pathology represent developmental interference of and adaptations to repeated or chronic exposure to interpersonal violence beginning in early childhood and occurring in the context of neglect, emotional abuse, and/or disrupted or disorganized attachment (see, e.g., the groundbreaking work of Herman, 1992; Kluft, 1985; Liotti, 1999; van der Hart, Nijenhuis & Steele, 2006). Today, with the growing field of Child Trauma, the National Child Traumatic Stress Network (NCTSN), and government-mandated child protection systems, more trauma-exposed children are being identified than ever before. Yet our diagnostic classification system lacks a diagnosis that can accurately capture the clinical presentations of those children who, without appropriate intervention, will grow into the adults served by many of ISST-D’s members.

As clinicians, we see what we are trained to see and we use the tools that are available to us. When Gabriela first came to us at age 10, we made an error. We saw a victim of isolated incidents of sexual abuse with PTSD and we treated her accordingly. Her PTSD symptoms improved and, as far as we knew, she put her sexual abuse experience in the past so that her healthy development, which had been briefly interrupted, could proceed. When she returned to our center at 16, if not for our knowledge of Gabriela’s previous treatment and her failure to remember it, we would have made the same error. We would have treated her abuse-related reexperiencing, avoidance, and hyperarousal, and we would have missed another opportunity to begin the process of addressing the pervasive symptoms that shaped Gabriela’s approach to relationships and to the world.

What if, when Gabriela had first come to us at 10, a child diagnosis had existed that accurately described the complex developmental effects of chronic traumatic stress and early adverse experiences? What if we had had tools with which to assess for such a diagnosis? Would it have enabled us to better see Gabriela’s mother’s unresolved history of childhood sexual abuse and how

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it shaped their relationship? Would we have been more likely to discover that Gabriela had witnessed ongoing violence and conflict between her parents as a small child? Or that Gabriela was continuing to be sexually victimized even as we were working to help her heal from the effects of sexual abuse? Would we have been more likely to understand that Gabriela had already developed sophisticated skills to shut down her ability to feel “undesirable” affects while her experiences interfered with her development of a coherent identity or the skills needed to negotiate relationships with peers? And would we have provided treatment that not only addressed discrete episodes of abuse, but also worked to repair the attachment between Gabriela and her mother, to habilitate developmental competencies, and to integrate the aspects of Gabriela’s self that had been split off? In doing so, could we have prevented Gabriela from growing up to be a 16-year-old well on her way to becoming an adult with DID?

Reason #2: Demands for “Evidence-Based” Practice

La Rabida’s Chicago Child Trauma Center, the NCTSN site that I direct, provides services exclusively to children who have experienced PTSD Criterion A Traumatic Stressors. Many of these children exhibit PTSD symptoms related to discrete traumatic events and benefit from short-term trauma-focused interventions. Over 1/3 of the children served at our center, however, have experienced two or more types of traumatic stress, and nearly 40% have histories of placement in foster or other substitute care. To meet these children’s complex treatment needs, we obtained a small grant to create a program for Multiply Traumatized Children in Foster Care. In addition to their histories of neglect and placement in foster care, the 50 children served in the program’s first three years had experienced an average of 2.65 traumatic stressors, as detailed below:

Domestic Violence	66%
Burns	22%
Physical Abuse	66%
Torture	18%
Sexual Abuse	46%
Witnessing Violent Crime	14%
Loss Through Violent Death	26%
Fire	12%

Interventions used in the program inte-

grate phase-oriented trauma-focused approaches with Attachment, Self-Regulation & Competency, a framework developed by Kristine Kinniburgh and Margaret Blaustein at The Trauma Center at Justice Resource Institute (Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005). The program has been dramatically successful, reducing the frequency of placement disruptions by 85% compared to the year prior to children’s entry into services. Our experience has demonstrated that, for many trauma-exposed children, the PTSD Criterion A fails to adequately capture the traumatic events that affect them or the contexts in which these events occurred. Our work has also shown us that, despite the complexity of their symptoms, when these children receive treatment that facilitates the integration of discrete traumas and addresses their attachment histories and capacity for emotional and behavioral regulation, they feel and do better. As I discuss below, however, if the existing diagnostic classification system remains unchanged, it is unlikely that interventions such as these will be made available on a large scale to those who most need them.

In recent years, much emphasis has been placed on the need for practitioners to employ “evidence-based” practices. Interventions are ranked according to the quantity and quality of treatment outcome research supporting their efficacy, with Random Clinical Trials as the “gold standard.” The demand for interventions to be “evidence-based” is especially salient in state service systems responsible for large numbers of children with complex trauma histories, such as child welfare or juvenile justice. Administrators want to know that the services for which they pay, and which the children in their systems receive, are scientifically based and more helpful than harmful. As a result, child service systems administrators, if they want children to receive trauma services, will most likely select a scientifically well-supported treatment for simple PTSD, such as Trauma-Focused Cognitive Behavioral Therapy (e.g., Cohen, Mannarino, & Knudsen, 2005), even if many of the children in those systems would have been excluded from the studies upon which the ranking of the treatment was based (for an excellent review of the populations studied in PTSD treatment outcome research, see

Spinazzola, Blaustein, & van der Kolk, 2005).

For those of us who treat children with complex trauma histories, this creates a major conundrum. One cannot effectively conduct treatment outcome research without a group of subjects who share a clearly defined disorder that is the focus of treatment. Without a scientifically supported diagnosis for children coping with complex trauma, the “Promising Practices” developed for treating these children (see Amaya-Jackson & DeRosa, 2007) can never develop the scientific evidence base to advance to a ranking of “Well Supported and Efficacious.”

Reason #3: No Diagnosis No Payment

This reason, while it is linked to the first two, is the least complex and possibly the most important justification for a new diagnosis. Services cost money and, to put it simply, in order bill a third party payer, a practitioner must make a diagnosis. The amount and type of treatment that will be covered, then, will depend on knowledge and convention regarding what is required given that diagnosis. For children whose development has been impeded and shaped by their experience of complex trauma, however, none of the available diagnoses really fit. Consequently, children may be diagnosed with PTSD, which, because of the existence of evidence-based treatments, limits the number of sessions that will be covered. Alternative diagnoses, such as other Anxiety Disorders, Oppositional Defiant Disorder, or Conduct Disorder, dictate treatment focused on modification of current cognitions or behaviors without addressing the impact of past injuries. Finally, increasingly, and of most concern, children may receive diagnoses such as Bipolar Disorder or ADHD, which dictate that treatment must include powerful psychotropic medications that are in many cases not helpful to traumatized children. One of the most important results of the inclusion of PTSD in DSM-III (American Psychiatric Association, 1980) was that it enabled traumatized combat veterans and, later, other survivors of trauma to get treatment that would be covered. Similarly, a Developmental Trauma Disorder diagnosis for children will lead to greatly increased availability of treatments for those traumatized by complex trauma in childhood.

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Toward a DSM-V Developmental Trauma Disorder Diagnosis

Led by Bessel van der Kolk and Robert Pynoos, developmental and complex trauma experts affiliated with the NCTSN have been working to identify, refine, and eventually field test the DTD construct. The first step in this process was a theoretical one that included reviewing the published literature on complex trauma in order to derive a broad set of symptoms that could comprise preliminary proposed DTD criteria. In a parallel effort, for ISSD's first DSM-V Dissociative Disorders Research Planning Conference (RPC) in 2005, a Childhood Dissociative Disorders Work Group evaluated the need for child-sensitive diagnostic criteria for dissociative children. One of the recommendations that emerged from the RPC (also attended by van der Kolk) was to partner with and support the work of the NCTSN group in developing DTD criteria appropriate for "many (if not most) severely traumatized children" with "significant dissociative symptoms sufficient to include children with DDNOS-like clinical presentations" (Putnam, Silberg, Stolbach, & Waters, 2005).

Literature and theory about the developmental impact of complex trauma suggest that possible diagnostic criteria for DTD should cover numerous broad domains: Attachment; Biology; Affect Regulation; Dissociation; Behavioral Control; Cognition; and Self-Concept (Cook et al., 2005). The diagnosis should also capture triggered patterns of dysregulation, altered attributions and expectancies, and functional impairment of developmental competencies (van der Kolk, 2005). Guided by complex trauma literature and theory, members of the DTD Task Force are currently engaged in their next steps: collecting and analyzing data to determine whether empirical evidence supports the existence of DTD and operationalizing and refining proposed criteria. This multi-method, multi-site effort includes: analysis of existing sets of data from trauma-exposed children and children in child welfare or juvenile justice systems; collection and detailed analysis of clinical cases; and surveying a wide range of clinicians about symptoms presented by the children they treat, as well as the utility of existing and possible diagnostic criteria. If

this work leads to the conclusion that there is empirical support for a DTD diagnosis and that a set of symptoms exists that distinguishes children with DTD from others, the next step in the process will involve testing the validity and utility of diagnostic criteria derived from the data by prospectively assessing large numbers of children.

Creating and testing a scientifically derived, accurate, and useful diagnosis is no small task. It requires not only a true and deep understanding of the clinical presentations and needs of the children we serve, but also the cooperation and collaboration of experts with diverse perspectives who must be prepared to set aside strongly held beliefs about child development, attachment, and trauma, and allow empirical data to dictate the outcome of the process. If we are successful, the payoff will be tremendous for the many children affected by complex trauma. Just as the creation of PTSD in the DSM-III transformed the health care system for individuals exposed to traumatic stress and led to an explosion of specialized research and practice, the inclusion in the DSM-V of a clinically accurate and useful diagnosis for children whose development has been shaped by complex trauma will be a powerful catalyst for transformation of the systems that serve children. It will change the way clinicians, who must learn the contents of the DSM, are trained. It will make it possible for new and better research on intervention to take place and will lead to the development of "Well Supported and Efficacious" treatments for the pervasive developmental effects of complex trauma. It will enable clinicians to get paid for providing treatment for developmental trauma symptoms. Finally, and most importantly, it will make it possible for the thousands of children like Gabriela to get the help they need in order to heal during their childhoods, so that their lives will not be structured by the traumatic past and their healthy development may proceed.

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If a man dwells on the past, then he robs the present. But if a man ignores the past, he may rob the future. The seeds of our destiny are nurtured by the roots of our past.

Master Po

We are excited to announce our special 25th Anniversary Annual Conference as we return to Chicago, the location of our first conference. The theme of the conference is "Advances in Understanding Trauma and Dissociation: Personal Life, Social Process, and Public Health." This topic highlights our quarter century of endeavors to understand and treat the complex issues that can result from traumatic experiences and consequent dissociation.

In the past 25 years the dissociative disorders field has seen tremendous advances, in part, due to data mined from burgeoning psychobiological research. The field has opened its doors to a wealth of diverse theories regarding mental health and disease, and has made sustained efforts to develop best practices guidelines. Our current and future efforts are primarily directed to helping chronically traumatized individuals by

- developing more refined diagnostic and assessment protocols for disorders of chronic traumatization, particularly the dissociative disorders;
- testing best practices to develop evidence-based treatments for the complex comorbidity of chronically traumatized individuals;
- engaging in research on the biopsychosocial effects of chronic traumatization, especially dissociation; and
- educating professionals and the public on chronic traumatization and dissociation.

Great advances are being made with efficacy studies of short-term treatment interventions for PTSD, and these may be applied to selected chronically traumatized individuals. However, we recognize and

grapple with the severe limitations of these short-term treatments. These often do not adequately address the complex and wide-ranging psychological and relational struggles of chronically traumatized individuals, in particular those with complex dissociative disorders. In addition, our work extends well beyond the mental health needs of the individual. We recognize that chronic trauma, especially child maltreatment and

severe early attachment disruptions, has devastating and pervasive effects not only on the mind, but also on the body, on public health problems, and on societies at large. In addition to having some of the highest levels of mental health comorbidity, chronically traumatized individuals, including those with complex dissociative disorders, are also at unusually high risk for many of the leading causes of death, as well as other chronic physical health problems. The economic cost of this suffering can be counted in many billions of dollars each year. Ongoing social failures to realize the effects of chronic trauma prevent adequate research funding in the field, and inhibit sufficient education of clinicians in the assessment and treatment of the entire spectrum of trauma-related disorders, particularly dissociative disorders. As a result, the majority of patients with dissocia-

tive disorders are not properly diagnosed or treated in the first 6 to 8 years of their mental health treatment, even though chronically traumatized individuals represent a highly significant subset of those seeking mental health care. Our task is not only to continue integrating a broad base of knowledge within our field, but also to challenge ongoing personal, institutional, and social denial regarding the effects of trauma and

dissociation, and to address public health problems related to chronic trauma. We must disseminate greater understanding of chronic trauma and

dissociation to other areas of psychiatry and psychology, as well as to public health institutions, including child welfare, prisons, and primary health care. To this end, the 25th Annual Conference will address these issues and more.

The Call for Proposals for the conference will go out on February 1, 2008. Proposals should address trauma and/or dissociation. Topics are not limited to the theme of the conference. Proposals should be developed by using scientific, clinical, and intellectual methods that are rigorous, principled, and creative. Formats include workshops (mini and half day), symposia, panels, forums, papers, or posters.

We look forward to receiving your submissions. Proposals may be submitted online through the ISSTD website at <http://www.isst-d.org>

We invite you join us in participating in this special and exiting meeting that marks a quarter century of intense learning, collaboration, and growth.

Kathy Steele, MN, CS

Conference Chair

Vedat Şar, MD

President

25th Anniversary ISSTD Annual Conference

CHICAGO

Advances in Understanding Trauma and Dissociation: Personal Life, Social Process, and Public Health

Pre-conference Workshops November 14
November 15-17, 2008
Holiday Inn Mart Plaza Hotel

DDPTP To Enter a New Era of Course Offerings

Winter courses starting

Rich Chefetz, MD

DDPTP Administrative Director
r.a.chefetz@psychsense.net

The year 2008 promises to be a landmark year for ISSTD's flagship program, the Dissociative Disorders Psychotherapy Training Program. Having started in 2001 with a single, seminar style, introductory course in the diagnosis and treatment of the dissociative disorders, a course that Liz Bowman gave to us, we now have this Standard course, as well as an Advanced course, both in seminar and online, and a new Child & Adolescent course in seminar form. This winter, we are adding sites for the Child and Adolescent course in Minneapolis, Stockholm, near Huddersfield (between Manchester and Leeds) in the UK, and potentially also in the Netherlands, in addition to courses in Vancouver, Victoria, and the Michigan Upper Peninsula. I wish to express my gratitude to the core faculty of that program, Fran Waters, Joyanna Silberg, and Sandra Wieland, who have worked hard to make this course really go! They have also been consulting with Annita Jones, who administers our online programs, and it looks like there will be an online version of the Child & Adolescent program in fall 2008, or winter 2009. Stay tuned for that announcement.

So, what's all this "New Era" stuff?

Here's the deal: We are now the ISSTD, and to stay true to our name, this winter we are adding an introduction to trauma psychology in the context of chronic, complex trauma to our offerings. Intended for clinicians new to treating trauma, the format progresses from theories that focus on "single-blow" traumas through chronic and complex interpersonal traumas, and leading to a more advanced conceptualization of the interaction between trauma and dissociative adaptations that typically occur in survivors of many years of abuse. No experience treating dissociative disorders is needed to take this course. While previous courses have been in nine-session modules, the new introduction to trauma, the DDPTP-iT, will be offered in three, bite sized, six-session modules. The course will

be free of copyright fees because it uses texts and articles that ISSTD owns. So, it will cost somewhat less than other courses, too! We are still passing the curriculum around for comments from core faculty, as well as developing the first power point presentation to accompany one of our courses. It's a lot of work. We're all indebted to Don Fridley for spearheading this project. We expect the first module to launch this winter, and the second in the fall of 2008. Look for an announcement.

Some of our regular course offerings will launch in the dead of winter as Canadians venture out of their homes in Toronto to warm up to the hospitality of Clare Pain and Christine Dunbar. Check with them via the contact info at www.isst-d.org to learn more about that seminar. Seminars in New York City, with Elizabeth Howell, and Cincinnati, with Don Beere, are just getting ready to launch, and there is still time to sign up. Check our web page to reach them, too!

Coloradans (yep, the folks who live out yonder in Colorado), have a new option for learning at our new course site in Denver!

Ruth Blizard brings her several years experience of teaching the course in her former home in Binghamton, N.Y., and is teaming up with Peter Maves, an old hand in our field, to offer a Standard Course that will start this winter. Check out that info on our website!

Lastly, Elizabeth Howell has announced that she will step down from her Director's position late this Spring, and Rich Chefetz will also leave the program by the time of the Chicago meeting next November. Carefully selected replacements have their names before the Executive Council, for approval, and we should be able to announce this transition in the next newsletter.

We continue to be excited about our programs and the effect that education has in raising the standard of care for our patients. If you've never taken one of our courses, check with your colleagues, or write to me, Rich Chefetz, DDPTP Admin Director, r.a.chefetz@psychsense.net, and I'll tune you in to a learning community that will change your professional life for the better!

Thanks for listening!

Warmly, Rich



The Child and Adolescent Committee at the Philadelphia Conference

Guest, Na'ama Yehuda, New York, Fran Waters, Michigan, Sandra Wieland, Victoria, BC, Els Grimminck, Netherlands, Bengt Soderstrom, Sweden, Sandra Baita, Buenos Aires, Joy Silberg, Baltimore, Renee Potgieter, UK. Missing: Brad Stolbach, Chicago

2008 ISSTD PROFESSIONAL DEVELOPMENT SEMINARS

We are pleased to announce the schedule for the 2008 ISSTD Professional Development Seminars:

February 29/March 1, 2008

Fort Lauderdale, FL

Allan N. Schore, PhD

**The Science of the Art of Psychotherapy:
Psychotherapy for the 21st Century**

REGISTRATION OPEN

•

April 18, 2008

Baltimore, MD

Richard J. Loewenstein, MD

Joyanna Silberg

**Trauma, Dissociation, and Clinical Practice:
Childhood and Adult Manifestations**

of Psychological Trauma

REGISTRATION OPEN SOON

•

May, 2008

Minneapolis, MN

John Briere, PhD

**Advances in the Integrated Treatment
of Complex Trauma**

REGISTRATION OPEN SOON

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

ISSTD Component Group News

At the Component Group breakfast meeting in Philadelphia, it was announced that there are currently a total of 31 Component Groups. Four new groups have joined in the past year in various regions of the world including Japan, New Zealand, Paris, and Anchorage, Alaska.

There will be a 10% reduction of the yearly dues to Component Group members in order to encourage component group members to join the ISSTD.

Dennis Pilon has stepped down from his position as Component Group Committee chair after having served five years. His hard work and dedication to the Component Groups is much appreciated.

Rebeca Gonzalez has been appointed the new Component Group liaison.

Any interested ISSTD members and colleagues can find information about establishing a Component Group in your area by visiting the ISSTD website, Component Groups page. Check out the online ISSTD Component Society/Study Groups Guide, or contact the Component Group liaison, Rebeca Gonzalez, Psy.D., <docrebeca@yahoo.com >.



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A man can be broken by a strength outside, greater than himself; or a weakness inside, which he cannot understand.

Kwai Chang Caine



**ISSTD NEWS
to have
new editors,
web-based
format**

Caught In The Web

Stephen H. Snow, PhD
shsnow@mindspring.com

Our newsletter is going to the web! What does this mean? It means two main things: the web-look format will make it easy to read and, we hope, familiar to everyone. The newsletter will come to you by email but will allow you to read online without having to download or print out anything. Of course, for those who prefer paper, we'll offer a printable version, as well. It also means we can offer richer content by linking to multiple articles and references. As time passes, we will be able to enrich our content for you, including audio and video to augment the usual text articles. Our intent is to enhance an already-rich publication with even more depth, in a convenient, easy-to-read, multi-media format. In addition, we will be able to archive the newsletters online for easy reference.

Editor's note:

Steve Snow will be taking over as editor of the ISSTD News in January, 2008. Tara Williams will act as co-editor. She has been serving as editor of the Who's Who in ISSTD feature and was profiled in the May, 2007 issue.



Steve describes himself as follows:

Being a therapist is my third career. I spent 25 years in magazine and newspaper journalism as both a writer and an editor. That overlapped with 17 years in electronic media with a special focus on community applications of Internet technology, and founded the US Association For Community Networking in 1997. I continue to have a "toe in the water" in the Internet world and have an interest in using web technology to further therapeutic goals.

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ISSTD NEWS

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Kathy Steele, president-elect 2009, Atlanta, Catherine Classen, past president 2007, Toronto, Vedat Şar, president 2008, Istanbul, Eli Somer, past president 2006, Israel

*To suppress a truth, is to give it
force beyond endurance.*

Master Kan