NOTES

You are being provided with a book chapter by chapter. I will request you to read the book for me after each chapter. After reading the chapter, 1. shorten the chapter to no less than 300 words and no more than 400 words. 2. Do not change the name, address, or any important nouns in the chapter. 3. Do not translate the original language. 4. Keep the same style as the original chapter, keep it consistent throughout the chapter. Your reply must comply with all four requirements, or it's invalid.
I will provide the chapter now.

NOTES
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CHAPTER 1: LESSONS FROM VIETNAM VETERANS
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CHAPTER 7: GETTING ON THE SAME WAVELENGTH, ATTACHMENT AND ATTUNEMENT

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CHAPTER 8: TRAPPED IN RELATIONSHIPS: THE COST OF ABUSE AND NEGLECT

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CHAPTER 9: WHAT'S LOVE GOT TO DO WITH IT?

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CHAPTER 10: DEVELOPMENTAL TRAUMA: THE HIDDEN EPIDEMIC

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16. Our work group consisted of Drs. Bob Pynoos, Frank Putnam, Glenn Saxe, Julian Ford, Joseph Spinazzola, Marylene Cloitre, Bradley Stolbach, Alexander McFarlane, Alicia Lieberman, Wendy D’Andrea, Martin Teicher, and Dante Cicchetti.

17. The proposed criteria for Developmental Trauma Disorder can be found in the Appendix.

18. http://www.traumacenter.org/products/instruments.php.

19. Read more about Sroufe at www.cehd.umn.edu/icd/people/faculty/cpsy/sroufe.html and more about the Minnesota Longitudinal Study of Risk and Adaptation and its publications at http://www.cehd.umn.edu/icd/research/parent-child/ and http://www.cehd.umn.edu/icd/research/parent-child/publications/. See also L. A. Sroufe and W. A. Collins, The Development of the Person: The Minnesota Study of Risk and Adaptation from Birth to Adulthood (New York: Guilford Press, 2009); and L. A. Sroufe, "Attachment and Development: A Prospective, Longitudinal Study from Birth to Adulthood," Attachment & Human Development 7, no. 4 (2005): 349–67.
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23. For children who were physically abused, the chance of being diagnosed with conduct disorder or oppositional defiant disorder went up by a factor of three. Neglect or sexual abuse doubled the chance of developing an anxiety disorder. Parental psychological unavailability or sexual abuse doubled the chance of later developing PTSD. The chance of receiving multiple diagnoses was 54 percent for children who suffered neglect, 60 percent for physical abuse, and 73 percent for both sexual abuse.
24. This was a quote based on the work of Emmy Werner, who has studied 698 children born on the island of Kauai for forty years, starting in 1955. The study showed that most children who grew up in unstable households grew up to experience problems with delinquency, mental and physical health, and family stability. One-third of all high-risk children displayed resilience and developed into caring, competent, and confident adults. Protective factors were 1. being an appealing child, 2. a strong bond with a nonparent caretaker (such as an aunt, a babysitter, or a teacher) and strong involvement in church or community groups. E. E. Werner and R. S. Smith, Overcoming the Odds: High Risk Children from Birth to Adulthood (Ithaca and London: Cornell University Press, 1992).
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26. In the sixty-three studies on disruptive mood regulation disorder, nobody asked anything about attachment, PTSD, trauma, child abuse, or neglect. The word "maltreatment" is used in passing in just one of the sixty-three articles. There is nothing about parenting, family dynamics, or about family therapy.
27. In the appendix at the back of the DSM, you can find the so-called V-codes, diagnostic labels without official standing that are not eligible for insurance reimbursement. There you will see listings for childhood abuse, childhood neglect, childhood physical abuse, and childhood sexual abuse.
28. Ibid., p 121.

29. At the time of this writing, the DSM-5 is number seven on Amazon's best-seller list. The APA earned $100 million on the previous edition of the DSM. The publication of the DSM constitutes, with contributions from the pharmaceutical industry and membership dues, the APA's major source of income.
30. Gary Greenberg, The Book of Woe: The DSM and the Unmaking of Psychiatry (New York: Penguin, 2013), 239.
31. In an open letter to the APA David Elkins, the chairman of one of the divisions of the American Psychological Association, complained that DSM-V was based on shaky evidence, carelessness with the public health, and the conceptualizations of mental disorder as primarily medical phenomena." His letter attracted nearly five thousand signatures. The president of the American Counseling Association sent a letter on behalf of its 115,000 DSM-buying members to the president of the APA, also objecting to the quality of the science behind DSM-5—and "urge(d) the APA to make public the work of the scientific review committee it had appointed to review the proposed changes, as well as to allow an evaluation of "all evidence and data by external, independent groups of experts."
32. Thomas Insel had formerly done research on the attachment hormone oxytocin in non-human primates.
33. National Institute of Mental Health, "NIMH Research Domain Criteria (RDoC)," http://www.nimh.nih.gov/research-priorities/rdoc/nimh-research-domain-criteria-rdoc.shtml.
34. The Development of the Person: The Minnesota Study of Risk and Adaptation from Birth to Adulthood (New York: Guilford Press, 2005).
35. B. A. van der Kolk, "Developmental Trauma Disorder: Toward a Rational Diagnosis for Children with Complex Trauma Histories," Psychiatric Annals 35, no. 5 (2005): 401–8; W. D'Andrea, et al., "Understanding Interpersonal Trauma in Children: Why We Need a Developmentally Appropriate Trauma Diagnosis," American Journal of Orthopsychiatry 82 (2012): 187–200. J. D. Ford, et al., "Clinical Significance of a Proposed Developmental Trauma Disorder Diagnosis: Results of an International Survey of Clinicians," Journal of Clinical Psychiatry 74, no. 8 (2013): 841–849. Up-to-date results from the Developmental Trauma Disorder field trial study are available on our Web site: www.traumacenter.org.
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CHAPTER 11: UNCOVERING SECRETS: THE PROBLEM OF TRAUMATIC MEMORY

1. Unlike clinical consultations, in which doctor-patient confidentiality applies, forensic evaluations are public documents to be shared with lawyers, courts, and juries. Before doing a forensic evaluation I inform clients of that and warn them that nothing they tell me can be kept confidential.
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5. Y. D. Van Der Werf, et al. “Special Issue: Contributions of Thalamic Nuclei to Declarative Memory Functioning,” Cortex 39 (2003): 1047–62. See also B. M. Elzinga and J. D. Bremner, “Are the Neural Substrates of Memory the Final Common Pathway in Posttraumatic Stress Disorder (PTSD)?” Journal of Affective Disorders 70 (2002): 1–17; L. M. Shin et al., “A Functional Magnetic Resonance Imaging Study of Amygdala and Medial Prefrontal Cortex Responses to Overtly Presented Fearful Faces in Posttraumatic Stress Disorder,” Archives of General Psychiatry 62 (2005): 273–81; L. M. Williams et al., “Trauma Modulates Amygdala and Medial Prefrontal Responses to Consciously Attended Fear,” Neuroimage 29 (2006): 347–57; R. A. Lanius et al., “Brain Activation During Script-Driven Imagery Induced Dissociative Responses in PTSD: A Functional Magnetic Resonance Imaging Investigation,” Biological Psychiatry 52 (2002): 305–311; H. D Critchley, C. J. Mathias, and R. J. Dolan, “Fear Conditioning in Humans: The Influence of Awareness and Autonomic Arousal on Functional Neuroanatomy,” Neuron 33 (2002): 653–63; M. Beauregard, J. Levesque, and P. Bourgouin, “Neural Correlates of Conscious Self-Regulation of Emotion,” Journal of Neuroscience 21 (2001): RC165; K. N. Ochsner et al., “For Better or for Worse: Neural Systems Supporting the Cognitive Down- and Up-Regulation of Negative Emotion,” NeuroImage 23 (2004): 483–99; M. A. Morgan, L. M. Romanski, and J. E. LeDoux, et al., “Extinction of Emotional Learning: Contribution of Medial Prefrontal Cortex,” Neuroscience Letters 163 (1993): 109–13; M. R. Milad and G. J. Quirk, “Neurons in Medial Prefrontal Cortex Signal Memory for Fear Extinction,” Nature 420 (2002): 70–74; and J. Amat, et al., “Medial Prefrontal Cortex Determines How Stressor Controllability Affects Behavior and Dorsal Raphe Nucleus,” Nature Neuroscience 8 (2005): 365–71.
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of Memory and the Engraving of Trauma," Imago 48 (1991): 425–54.
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18. P. Janet, Psychological Healing (New York: Macmillan, 1925); p 660.
19. P. Janet, L'Etat mental des hystériques, 2nd ed. (Paris: Félix Alcan, 1911; repr. Marseille, France: Lafitte Reprints, 1983). P. Janet, The Major Symptoms of Hysteria (London and New York: Macmillan, 1907; repr. New York: Hafner, 1965); P. Janet, L'evolution de la memoire et de la notion du temps (Paris: A. Chahine, 1928).
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CHAPTER 12: THE UNBEARABLE HEAVINESS OF REMEMBERING

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9. Ibid., pp. 192–93.
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18. Every single scientific study of memory of childhood sexual abuse, whether prospective or retrospective, whether studying clinical samples or general population samples, finds that a certain percentage of sexually abused individuals forget, and later remember, their abuse. See, e.g., B. A. van der Kolk and R. Fisler, "Dissociation and the Fragmentary Nature of Traumatic Memories: Overview and Exploratory Study," Journal of Traumatic Stress 8 (1995): 505–25; J. W. Hopper and B. A. van der Kolk, "Retrieving, Assessing, and Classifying Traumatic Memories: A Preliminary Report on Three Case Studies of a New Standardized Method," Journal of Aggression, Maltreatment & Trauma 4 (2001): 33–71; J. J. Freyd and A. P. DePrince, eds., Trauma and Cognitive Science (Binghamton, NY: Haworth Press, 2001), 33–71; A. P. DePrince and J. J. Freyd, "The Meeting of Trauma and Cognitive Science: Facing Challenges and Creating Opportunities at the Crossroads," Journal of Aggression, Maltreatment & Trauma 4, no. 2 (2001): 1–8; D. Brown, A. W. Scheflin, and D. Corydon Hammond, Memory, Trauma Treatment and the Law (New York: Norton, 1997); K. Pope and L. Brown, Recovered Memories of Abuse: Assessment, Therapy, Forensics (Washington: American Psychological Association, 1996); and L. Terr, Unchained Memories: True Stories of Traumatic Memories, Lost and Found (New York: Basic Books, 1994).
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Memories and Allegations of Sexual Abuse (New York: Macmillan, 1996).
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29. Ibid., p.5.
30. L. L. Langer, op cit., p. 21.
31. L. L. Langer, op cit., p. 34.
32. J. Osterman and B. A. van der Kolk, “Awareness during Anaesthesia and Posttraumatic Stress Disorder,” General Hospital Psychiatry 20 (1998): 274-81. See also K. Kiviniemi, “Conscious Awareness and Memory During General Anesthesia,” Journal of the American Association of Nurse Anesthetists 62 (1994): 441–49; A. D. Macleod and E. Maycock, “Awareness During Anaesthesia and Post Traumatic Stress Disorder,” Anaesthesia and Intensive Care 20, no. 3 (1992) 378–82; F. Guerra, “Awareness and Recall: Neurological and Psychological Complications of Surgery and Anesthesia,” in International Anesthesiology Clinics, vol. 24. ed. B. T Hindman (Boston: Little Brown, 1986), 75–99; J. Eldor and D. Z. N. Frankel, “Intra-anesthetic Awareness,” Resuscitation 21 (1991): 113–19; J. L. Breckenridge and A. R. Aitkenhead, “Awareness During Anaesthesia: A Review,” Annals of the Royal College of Surgeons of England 65, no. 2 (1983), 93.

CHAPTER 13: HEALING FROM TRAUMA: OWNING YOUR SELF

1. “Self-leadership” is the term used by Dick Schwartz in internal family system therapy, the topic of chapter 17.
2. The exceptions are Pesso’s and Schwartz’s work, detailed in chapters 17 and 18, which I practice, and from which I have personally benefited, but which I have not studied scientifically —at least not yet.
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CHAPTER 14: LANGUAGE: MIRACLE AND TYRANNY

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CHAPTER 15: LETTING GO OF THE PAST: EMDR

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CHAPTER 16: LEARNING TO INHABIT YOUR BODY: YOGA

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CHAPTER 17: PUTTING THE PIECES TOGETHER: SELF-LEADERSHIP

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CHAPTER 18: FILLING IN THE HOLES: CREATING STRUCTURES

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CHAPTER 19: REWIRING THE BRAIN: NEUROFEEDBACK

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21. In chapter 17, we saw how essential it is to cultivate a state of steady, calm self-observation, which IFS calls a state of “being in self.” Dick Schwartz claims that with persistence anybody can achieve such a state, and indeed, I have seen him help very traumatized people do precisely that. I am not that skilled, and many of my most severely traumatized patients become frantic or spaced out when we approach upsetting subjects. Others feel so chronically out of control that it is difficult to find any abiding sense of “self.” In most psychiatric settings people with these problems are given medications to stabilize them. Sometimes that works, but many patients lose their motivation and drive. In our randomized controlled study of neurofeedback, chronically traumatized patients had an approximately 30 percent reduction in PTSD symptoms and a significant improvement in measures of executive function and emotional control (van der Kolk et al., submitted 2014).
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CHAPTER 20: FINDING YOUR VOICE: COMMUNAL RHYTHMS AND THEATER

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