Photo: Manuel Meurisse, Lofoten Norway

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ESTD NEWSLETTER

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Table of contents

QUARTERLY QUOTE

Olivia Laving

"We aren't as solid as we once thought. We're embodied but we're also networks, expanding out into empty space, living on inside machines and in other people's heads, memories and data streams as well as flesh. We're being watched and we do not have control. We long for contact and it makes us afraid. But as long as we're still capable of feeling and expressing vulnerability, intimacy stands a chance."

Anca Vilma Sabau
ESTD President

LETTER FROM THE PRESIDENT

I hope this letter finds you well.

In the last 3 months we all went through difficult and challenging realities. The COVID 19 pandemy has changed our lives at a personal and professional level. Most of us have experienced the psychological and social effects of lockdown, whilst trying to adapt to new ways of working with our clients or students using the online tools. Some of us found it difficult to work in this virtual reality; in some cases the feedback from our clients, especially in complex cases, was not so positive. During this period, both therapists and patients experienced some type of loss with regard to finances, friends, and sickness to the death of a loved one. We all got in touch with some form of pain, we all experienced the unsafe feeling. We have to be aware of it and take gentle care of ourselves.

Unfortunately, this stress is not gone; we are aware that the future will require constant adaptation. With that in mind, we have to focus on strengthening our resilience and find ways to reconnect in a meaningful way in this new context. As reports from WHO and UNESCO show, during the COVID 19 pandemic there has been a rise in violence and hate online. Due to lockdown in many countries, vulnerable populations are more exposed to domestic violence and sources of support like community centres, friends or therapists are partly reduced. Patients had to adapt to find help through online sessions, which was not so easy.

The Education Department at ESTD managed to highlight two important online materials, one is Self Caring for the Therapist by Anabel Gonzalez, MD., The other is a series of small videos that discuss grounding and containment techniques, presented by Ellen Jepsen PhD. Professor Andrew Moskowitz PhD kindly made possible free access to a webinar on the basic concepts of trauma, dissociation and attachment. We thank our colleagues for their efforts! The online work in presenting new materials will continue in the next months, in order to support the learning needs of our members. As we have seen in different countries, local online intervision and supervision groups were developed so therapists could find more anchors for their work. The ESTD Conference that was scheduled in Manchester, 2021, bearing in mind the circumstances we expect for next year (safety, difficulty in flying, financial reasons, etc), has been postponed until 2022. Meanwhile, ESTD is open to support our ESTD UK colleagues in organising their national ESTD Conference scheduled for the Autumn 2021, especially regarding an online aspect. Discussions are open regarding this.

There is some good news regarding the ESTD Journal, The Journal is referenced in Scopus and, mindful of the various complaints regarding access, our colleague Raphael Gazon is working on the creation of an easy direct access through the editor's webpage.

Our goal is to increase communication between members and the Board in order to fulfil the new realities. You are welcome to contact us at membership@estd.org, and one of our Board colleagues will get in touch with you. We are a network of clinicians and researchers, so we are here to support each other.
I wish you a peaceful Summer and holiday time and good strength in your work,

Anca Vilma Sabau, MD
President, ESTD

Orit Badouk Epstein

By: Valerie Sinason

With the new edition of the ESTD newsletter arriving through our cyber-post-boxes, one familiar name and voice is missing.

Orit Badouk Epstein, a passionate attachment based psychoanalytic psychotherapist from the U.K. who trained at the Bowlby Centre, where she now teaches and supervises, has stepped down as co-editor of the newsletter after a long and sparkling contribution. She was with the newsletter from its very start over ten years ago and has put in a decade's worth of collaboration and inspiration. As a contributing co-editor she not only regularly wrote articles but also film, book and exhibition reviews, as well as encouraging others to contribute .

She remains Editor of the journal, Attachment: New Directions in Psychotherapy and Relational Psychoanalysis (published by Phoenix Publishing House), co-author of the books "Ritual Abuse and Mind Control: The Manipulation of Attachment Needs" (Badouk, Epstein, Wingfield & Schwartz, 2011 Karnac), "Terror Within & Without" (Yellin, Badouk, & Epstein, 2013, Karnac) and many papers, chapters and conference presentations.

We will miss her sparkly creative voice although we hope she will still provide an occasional review. Orit enjoys the cinema, reading philosophy and writing poetry and deserves more personal writing time. We look forward to hearing her voice in further writing. Only this time we will be reviewing her work! Thank you Orit from all of us.

CULTURALLY SENSITIVE TRAUMA TREATMENT IN THE ORTHODOX JEWISH COMMUNITY IN ISRAEL

By: Edna Ludmir

Increased clinical attention has been paid in recent years to the deep, and often inextricable, connection between childhood sexual trauma and dissociative disorders. What for years had been labeled an independent psychopathology is finally being re-recognized for what it is – a vital coping mechanism that protects individuals facing unbearable catastrophe from the complete collapse of the psyche. While dissociation is an intrapsychic and interpersonal function put to use by both children and adults contending with various types of trauma, it is particularly relevant for victims of child sexual abuse, as it enables them to function, survive and develop through the horror they face at the hands of their abusers. Recognition of the original source of this emotional mechanism, as well as the essential role it serves, has enabled the clinical world to develop relevant and suitable therapeutic treatment options, allowing for better integration and healing (Herman, 1992; Van der Hart, Nijehuis, & Steele, K., 2006). However, sexual abuse does not occur in a vacuum, nor does it occur solely on an individual level. Rather

it takes place within, and bi-directionally influences and is influenced by the broader communal and social context.

Throughout history, child sexual abuse (CSA) has been shaped, enabled, ignored, denied, silenced and/or perpetuated by the very communities in which it occurs (Van der Hart et al., 2016; Somer, 2016). However, while there has been progress in terms of the acknowledgement of CSA and its sequelae, this awareness and developing body of knowledge has been slow to penetrate closed communities in general, and the Orthodox Jewish community in particular. This lacuna has left Orthodox victims of CSA suffering in isolation, silence and secrecy, resulting in a deep and painful experience of dissociation - for what cannot be seen and owned by society, becomes hidden and separated from the self. Depersonalization and de-realization become the key for survival, allowing for the continuation of the communal order while claiming a heavy biopsychosocial price from the victim. It is therefore critical to recognize the role that community ignorance and neglect play on the individual victim and on dissociative processes. Specifically, the importance of a 'seeing other' has long been recognized for the crucial role it plays in allowing the self to face the atrocities suffered, and to personalize, realize and heal from the trauma (Liotti, 1992, 1999, 2006, 2009; Brown, & Elliot, 2016) Without that 'seeing other' the suffering becomes endless, and fails to reach an 'act of triumph' and completion (Janet, 1919/1925; Ogden, 2019).

The characteristics of closed societies, including the tendency for the common good to outweigh individual needs, the hierarchical religious system and the shielding of perpetrators for fear of tainting the community reputation, leaves few options for victims of relational traumata. Left unaddressed, sexual crimes against children transform the family and community into fickle platforms, whereby elevated and idealized religious values and structures, originally intended for safekeeping and morality, can be intentionally distorted and utilized by perpetrators as tools of manipulation, control and violation. Victims traumatized within this religious system which failed to protect them in the way that it was intended to, experience a major internal contradiction which often turns into an added source of confusion, guilt and shame.

In my years of work as a trauma clinician at the Lotem Trauma Center in the Tel Aviv Medical Centre treating the first victims coming forward from the Orthodox community, the catastrophic scope of the silenced phenomenon of CSA in this highly insular community began to unveil. I bore witness to the predicament and multi-level effects faced by CSA victims in a dissociated society that was blind to crimes perpetrated in their own homes. In 2013, with the understanding that in order to effectively treat and eradicate sexual abuse both the individual and social levels must be culturally understood and professionally addressed, the Benafshenu Center of Bayit Cham org. was established.

In this paper I present a unique culturally sensitive and community-centered approach to the treatment of CSA in the Orthodox Jewish community. The model has been developed into a working paradigm which has been successfully implemented through Benafshenu, a unique, culturally sensitive, multidisciplinary, cutting edge trauma treatment center, operated by Bayit Cham - a mental health organization. Located in the heart of Bnei Brak, Israel, the epicenter of Orthodox Jewish life, Benafshenu has been operating for the past six years, and has since expanded through multiple satellite centers spread throughout the country. It is the first government-funded treatment center for Orthodox adult survivors of CSA in the world. It was developed by, for and within this unique segregated community, whose core structures, values and practices have shaped a complex reality for sexual abuse victims. The process of working with this cloistered community, and supporting them in acknowledging, owning, taking responsibility for and addressing their deepest pain, is revolutionary. Its impact can be largely attributed to the perspective of 'communal dissociation' which helped the therapeutic team maintain their compassion as well as their

professional positions, while working in a society blind to its catastrophe. Viewing the collective dissociation, and understanding its survival role, has enabled a collaborative and healing approach towards both the victims and the community as a whole.

This paper will give a basic overview of the unique cultural characteristics of trauma work in the religious community with regard to the: (1) psychosocial aspects; (2) individual intra-psychic aspects; and (3) integration between the personal and community aspects.

The Psychosocial Context

The Orthodox Community is a traditional, conservative and strictly religious society living in the state of Israel and spread throughout the world. The community adheres to and preserves ancient Jewish law, customs and values through strict individual and group practices, safeguarded by segregation from modern liberal society and values. Central to Orthodox life is a stringent Code of Law that dictates every aspect of life – from food and dress, to intimacy, marriage, employment and education. Faith and 'halacha', the Jewish code of law, are at the center of existence. Social affiliation is core and imperative. Orthodox religiosity binds individuals and community into an inseparable dyad, dependent and influencing one another. Many religious tenants are not accessible on an individual basis, making upholding religious life almost impossible without community.

Promoting community survival, Jewish law includes strict commandments against gossiping, shaming and 'mesira' - sharing negative information about fellow Jews, both within and outside the narrow confines of the community. These values, embodied in a complex legal system, reflect the visceral need to keep the nations' security and holiness. Carved and pulsing within the Jewish community's DNA is both its ancient and recent painful history of persecution and annihilation. Community cohesion, encouraged through the deeply ingrained value of "arevut hadadit" – mutual responsibility, has been a primary survival mechanism, protecting this small nation through ceaseless suffering and trauma engraved on the national body, serving as a constant reminder of the importance of community and the cost of communal collapse.

The Orthodox community is family-centered and seeks to embody and preserve timeless values such as "Kavod habriyut" - human dignity and "tzniut" and "kedusha" - modesty and holiness. Respect for parents and elders is at the top of the religious hierarchy and, as such, Jewish wisdom is highly occupied with family law and customs pertaining to intimacy, marriage and childbearing.

Historically, Orthodox Judaism is a male and adult-dominated religion. Upholding the knowledge of the "Torah" as the pinnacle of life, men, who have been exclusively granted access to that wisdom, are authorized to interpret and enforce Jewish legislation. Women often face extreme difficulty navigating and advocating within this male-dominated system, and children are taught to respect those in possession of that wisdom – namely, parents, elders and "Talmidei chachamim" those who are students of the scriptures. While historically this role was given to males with the intended responsibility of protecting weaker members of society, it is sometimes cynically exploited by perpetrators.

"Tov Shem Mi'shemen Tov", "a worthy reputation is better than good oil" (Ecclesiastes, 7), is a key principle reflecting the implicit social rules of the Orthodox community. Specifically, the authenticity and integrity of one's reputation has significant personal and professional implications for both the individual themselves and their immediate and extended families. One's name and lineage are vital assets and can serve to determine future business and marriage prospects for generations ahead. Individual's socially deemed shame can be automatically transferred unto the entire family, lowering their social worth. The very real fear of public shame, stigmatization, retribution and ostracism makes disclosing sexual abuse extremely

difficult, and secrecy becomes a familial and communal solution.

These fundamental systems – family, community, religious hierarchy, and legislation – that are the basis of orthodox life, paradoxically when coinciding with relational atrocities, may turn into a double-edged sword for victims. And so, in face of unbearable evil, the collapse of the built-in protection, and tremendous fear of humiliation, they often turn to dissociation as the only means of escape (Van der Hart & Rydberg, 2019).

The Intra-psychic Experience

In Orthodox life, religious upbringing begins from an exceedingly early age and is directed towards the inhibition of instinct, the strengthening of morality and the building of faith. The aim is to raise a child into a moral adult. Strong boundaries are set, and commandments address minute daily activities that are intended to mold the personality towards these goals and elevate natural drives and behaviors into higher spiritual deeds: dietary laws, dress codes, hygiene practices and intimacy laws aim to elevate the materialistic to spiritual and sculpt morality. Sexual trauma, specifically incest, the ultimate shattering of boundaries, place a brutal and unbearable contradiction on the child raised in this fashion. From the earliest stage of development, the language of education correlates with religious values and ideas and utilizes distinct semantics: right vs. wrong, good vs. bad, righteous vs. sinful and reward vs. punishment. While meant to uphold morality, when in traumatic survival mode, this dichotomist language can further enhance guilt, shame and the feeling of self-hate and contamination - the hallmark of victims' inner experience.

With the aim of the preservation of tzniut (modesty) and kedusha (holiness), sexual organs and issues are not discussed until engagement and marriage. Sexual identity, feelings, impulses and abuse remain muted. Sexual education hardly exists, and so language and context is nonexistent. Emotional, mental or interpersonal space through which violations and abuse can be understood or processed is unavailable. This vacuum significantly increases vulnerability, leaving an empty lacuna in the psyche that does not enable symbolism or understanding, and makes accessing and navigating potential support nearly impossible (Stern, 2003).

The individual psychological experience of abuse draws upon the larger community context and has significant clinical implications. Specifically, belief in Divinity is the profound platform upon which CSA victims' deep feelings of shame and guilt fester. Violation of finite and all-powerful commandments relating to modesty and sex by perpetrators, albeit forced, is often interpreted by victims as sinful, and intensifies feelings of failure, ruin, self-hate and Divine punishment (Ferenczi, 1949; Mollon, 2016). The family and community negation of abuse often leaves victims feeling unworthy of Godly care, the lifeblood of this world and the next. 'The secret' takes on a larger than life quality, pushing intense dissociation and intrapsychic splits to develop. Holiness and sin, purity and shame, trust and betrayal, good and evil, belief and heresy mix and form chaos.

Reconciling the knowledge that people elevated to and valued for interpreting and embodying God's will can be the very ones perpetrating and/or preserving the darkest and most devastating pain is impossible. For a CSA victim it is unfathomable that this powerful religious system, one so thoroughly designed to uphold the highest social and moral values, is unable to protect from such terrible crimes. Conflicts about this paradox and the paramountcy of opposing religious values, can lead to silence, paralysis and amnesia, thereby preventing access to therapeutic treatment.

Patients abused while living in faith often present with a dissociative structure that is inclusive of parts of personality holding faith vs. other parts that are atheistic or heretics. Whether in emotional parts of personality (EP's) or apparently normal parts (ANP's), inner struggles about faith and religion prevail, while many times leading to a solution of "as if" religious life, in endless fluctuation between parts. These inner struggles often cause dysregulated behavior, dysregulated parenthood, and they disrupt relationships while raising self-negation and confusion leading to despair.

As such, dissociation is at times the only relevant and effective solution, enabling a disconnect from the inner dangers perceived to threaten individual and collective

consciousness and existence. Left untreated, dissociation becomes multi-generational, blinding and enabling devastating atrocities. It leaves its bearers unable to recognize or address this contradictory and evil reality, rendering prevention and protection irrelevant (Van der Hart, Nijehuis, & Steele, 2006; Chefetz, 2015).

The Therapeutic Relationship

Religious victims of CSA often come to therapy in secrecy. Having much to lose and conflicted as to what there is to gain, most live in dread of exposure, in utter loneliness and inner isolation (Herman, 1992). They may fear being seen entering the Center, and once in the room, present with an alexitemic silenced part of the personality.

For religious victims, the age at which they come to therapy for the first time tends to be younger than victims from secular populations. The reason for this is within the Jewish community, marriage and family are a primary cultural goal, and it is the norm for marriage prospects to begin at a young age (late teens/ early twenties). This positions CSA survivors in an impossible internal and external struggle between conflicting parts of themselves, social expectations and self-actualizing desires. Guilt, shame, a feeling of ruin and fear of contaminating those they come in contact with are at the core of inner experience; the phobia of change and losing social affiliation lurk in the shadows (Frankel, 2002). Belief in God's existence enters the therapy room, and the dyadic relationship between therapist and client expands to a triad between therapist, client, and God. Traumatic characteristics of inner representations are at times projected onto the image of God, and can take on various roles at different times and across parts; God can become the victim, the perpetrator, the punishing, the almighty, the helpless, the compassionate, the bearer or truth and/or the one who ignores the world and ignores their pain.

Traumatic transference and enactment - the materials of psychotherapy - are burdened with additional matrixes pertaining to a life of faith (Davis. & Frawley, 1994). In this fashion, the internalization of 'the pure' vs 'the sinful' comes to life in the dyad and plays a central role in the psychic theater. Therapist and client unknowingly enact these inner representations, causing much havoc in the relationship whilst the enactment remains dissociated. Fear of disintegration is often present, with the unasked and unanswered question of 'what is preferable - being insane or being a victim?'.

Effective therapeutic treatment for Orthodox victims of child sexual abuse need to address these psychological aspects. Unique dichotomous thinking structures and inner representations are central and addressed through the therapeutic relationship. For a religious CSA victim, the opportunity of 'playing' with similarity and differentiation in the working dyad with the religious therapist gives a chance to feel and work through experiences of rejection, self-hate, disconnect, negation and affiliation, and oftentimes pave the way back to connectedness.

Culturally Sensitive Trauma Work

Healing the dissociative split of both the individuals and communities that have been violated by sexual abuse happens through the process of integration. Namely, slowly, safely and sensitively recognizing, acknowledging, accepting, owning and integrating the fractured parts of community and self. Enhancing joint responsibility paves the way for healing and agency. It demands acknowledgement that neither the community nor the individual are evil or foolish for being blind to blatant afflictions, but rather have been living in survival mode that was an emotional must in face of perceived life-threatening reality.
And so, an effective culturally sensitive approach to treatment must respect and work within the structure of religious life, religious and communal values and nuances, and the complex interconnected community and familial systems. This approach should lead to suitable treatment for the high psychological and social price paid by victims and their families related to breaking the silence and sharing 'the secret'.

Benafshenu, Beyit Cham

Through its existence, location and therapeutic approach, the Benafshenu Centers, Beyit Cham,

make a social statement that addresses the intersecting experience of individual and communal dissociation. Through the patient, compassionate, professional and culturally sensitive perspective, collaboration is initiated. Offering programs addressing both top levels of leadership as well as individual survivors, the Center is creating meaningful change at multiple influential and intersecting levels of the community.

At the community level, its prominent main location in the centers of religious cities is the pinnacle of this integrative approach and is, in itself, a statement of acknowledgement and responsibility. Through targeted community outreach and training of key leaders and influencers, the Center's Education Department creates expansive change amongst school staff, marriage counselors, Rabbinic leaders and legal authorities who are supported, and in turn support, in preventing, identifying and treating sexual abuse. At the micro level, treating approximately 200 men and women suffering from CPTSD and complex dissociative disorders at any given moment, the Center has been able to support and facilitate movement towards change, slowly and steadily.

In a society that values the collective but is constrained by secrecy and silence, Benafshenu models respect for victims and their experiences, and facilitates social ownership of the abuse. Survivors return to their natural surroundings less dissociated and, in doing so, begin breaking the intergenerational communal cycle of abuse and neglect. Working at both the micro and macro levels within the Orthodox community, those same powerful and dissociated structures are being transformed into and becoming the very resources promoting this vital change. The large families and close-knit nature of the community, the high esteem for knowledge, morality and the law are the very resources enabling the integrative messages to spread quickly and thoroughly. The well-respected hierarchical system is now becoming the authority that is promoting and legislating sexual abuse prevention, reporting and responsibility. And with Benafshenu's culturally-sensitive professional support, communal strengths, values and attributes are being utilized to aid the healing the community needs and well deserves.

Collaborator: Ora Kalfa, MSW.

Acknowledgements: I would like to thank Rabbi Aryeh Munk, CEO Bayit Cham Org., for making Benafshenu a reality and for standing up for religious victims of child sexual abuse.

I would also like to thank Israel's Ministry of Social Services, Dr. Zivya Seligman, and the Lotem Center, and Mrs. Nancy and Mr. Dov Friedberg and the Friedberg Charitable Foundation for their essential role in founding Benafshenu and supporting the important work Benafshenu does in the Orthodox Jewish community in Israel.

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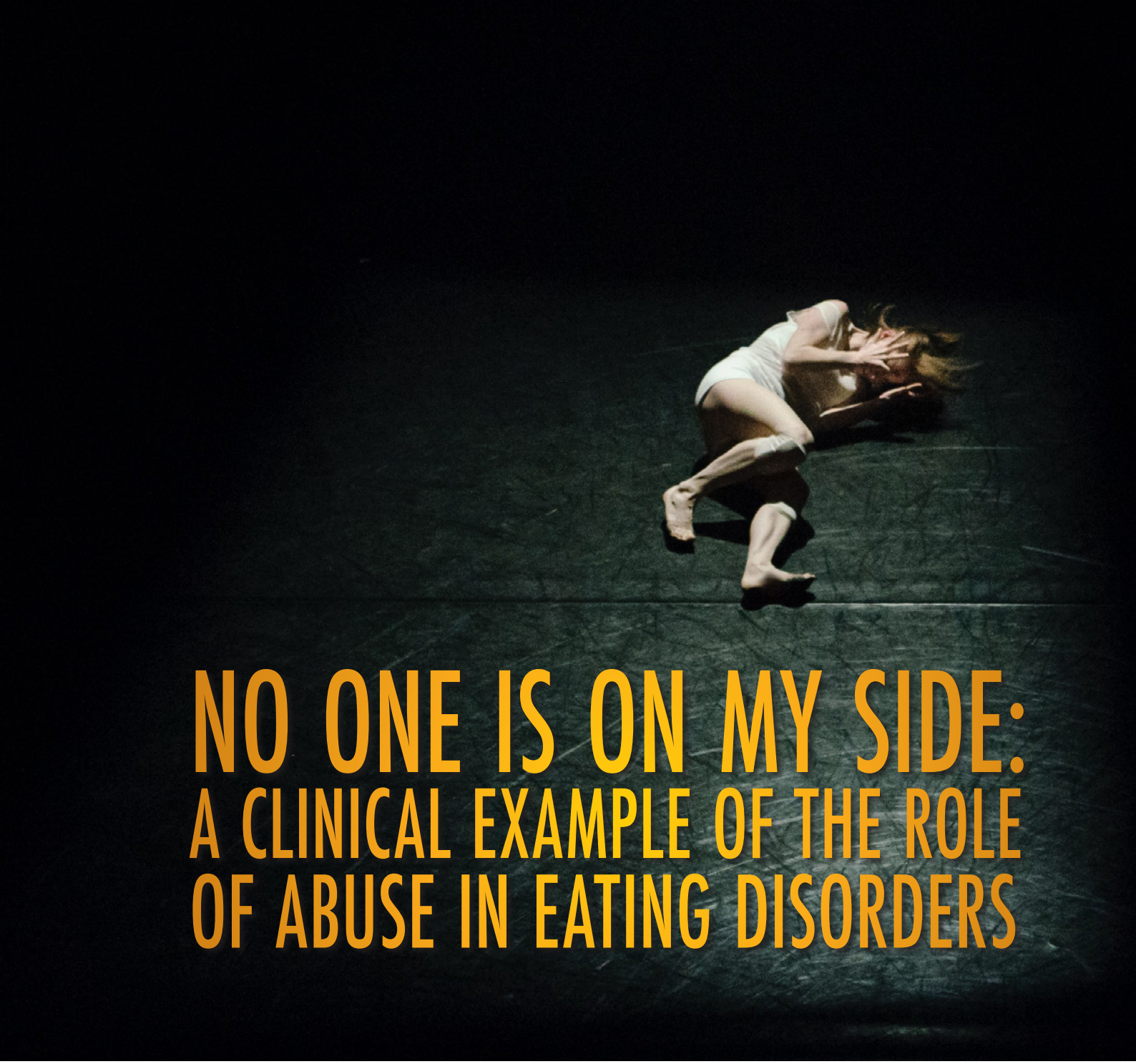

NO ONE IS ON MY SIDE: A CLINICAL EXAMPLE OF THE ROLE OF ABUSE IN EATING DISORDERS

By: Natalia Seijo

Abstract

Eating disorders are considered some of the most difficult to treat and have the highest mortality rate of all mental disorders (Agras, 2001). Among them, anorexia nervosa is one of the psychiatric diagnoses with the highest mortality rate (Arcelus et al., 2011). In a longitudinal study conducted by Bulkin et al. (2007) from 1980 to 2005, it was found that applying medication and working with behaviour yielded inconclusive results (Openshaw, et al. 2004). If eating disorders were solely dependent on food, it would make sense that changing eating behaviours makes it easier to recover from the disorder. Unfortunately, this is often not the case. The clinical case presented here is a clear example of the relationship between eating disorders and trauma, particularly sexual, emotional, power, and physical abuse.

The DSM-IV-TR (APA, 2000) established a lifetime prevalence of anorexia nervosa for women at approximately 0.5% (APA, 2000) and for men at approximately one tenth of that of women. The

current DSM-5 (APA, 2013) reflects a 12-month prevalence of anorexia nervosa among young women of approximately 0.4% and specifies that it is less common in men than in women, maintaining the DSM-IV-TR (APA, 2000) ratio of 10:1.

The DSM-IV-TR (APA, 2000) indicates a prevalence of bulimia nervosa among adolescent and young adult women of approximately 1-3%, with a tenfold lower prevalence in men. This condition occurs mainly in industrialized countries and, within these countries, in females, with at least 90% of the cases constituting the DSM-IV-TR (APA, 2000) ratio of 10:1.

The DSM-5 (APA, 2013) indicates that the 12-month prevalence of binge eating disorder in adults (18 years and older) is 1.6% in women and 0.8% in men. Similarly, it indicates that the disorder is more prevalent in those who are seeking to lose weight than in the general population.

The lethality of eating disorders is the highest among those detected in psychiatric disorders. Specifically, the lethality rate in anorexia accounts for 0.3%, bulimia about 0.8%, and non-specified eating disorders about 3.1% of the female population aged 12-21. If we consider the whole spectrum, taking into account the milder forms, the frequency estimate is much higher: between 11-16%.

Recent studies link posttraumatic stress disorder (PTSD) to eating disorders. They show results from approximately 75% of women in psychological treatment who suffered some form of trauma. Sexual and emotional abuse are the most common in these patients (Burns, 2012; Chou et al., 2012; Grillo & Masheb, 2001; Steiger et al., 2009). Identifying trauma and adverse life experiences in the biographies of these patients help to conceptualize the disorder and develop appropriate treatment for each case. In the treatment of eating disorders, attention continues to be paid to food behavior as a key part of the treatment, albeit with little effect. Usually, the reality of the problems with food lay in a patient's past, in the different traumatic events that force the person to survive these problems. This case study shows how trauma and the different types of abuse that a patient suffers throughout their life, are the basis of the severe disorder that they have suffered for years. Lack of attention by professionals to a patient's traumatic history puts their lives at risk and, in turn, leads to abuse of power generated by the treatment itself. With this case study, it is expected to shed light on and improve interventions for these patients, and to provide specialists with the ability to recognize the true origin of the problem.

This case study will show how trauma and abuse can be at the root of severe eating disorders. It will also demonstrate how a lack of attention, on the part of professionals, to a patient's traumatic past cannot only put a patient's life at risk but may also lead to power abuse during treatment. It is hoped that this case will enable specialists to better recognize the true origin of eating disorders and to improve interventions.

Reason for consultation

A 29-year-old patient requested a consultation to strengthen her social skills following recommendations from the eating disorder unit. She had been treated for 12 years for severe anorexia nervosa. However, her problems with food continued although the patient was out of risk.

During the collection of history, the patient describes her problems with food and her body since childhood; she relates, in the first years of school, she was insulted about her weight. At the age of 13, she began to develop restrictive anorexia nervosa which lasted throughout adolescence and part of adulthood. Her medical history includes three suicide attempts, for which she had to be admitted to hospital, and nine hospitalizations due to being underweight. At that time, she was fed by a probe because of her refusal to eat. Sexual abuse in childhood, emotional and physical abuse by the family and abuse of power appear in the different admissions where the patient describes the behaviour and treatment received from carers and professionals as traumatizing. The patient describes that during hospitalizations she was tied hand and foot to a bed facing the ceiling

for a week as part of a treatment to get better. She describes how she was forced to eat food of inferior quality and how, on one of her admissions, her roommate fell to the floor and died instantly.

The first treatment was carried out in an eating disorder unit for 12 years. During this time, eating guidelines, behaviours, and medication were monitored; the family was consulted to ensure that the standards established by the professionals were met.

During the anamnesis something important happened, which is worth mentioning since it is one of the keys to treatment - the patient's surprised reaction when asked if she had been sexually abused. She responded with surprise because she said it was the first time someone had asked her and that she was interested in knowing what had happened to her. Following this commentary, she was asked to describe, if possible, as much as she could about what had happened to her. She described sexual abuse in childhood from age 5 to 10 by a family friend. She said she tried to talk about the instances of abuse over the years. The first time she tried was at age of 7 with her mother, but she excused the abuser by associating his behaviours with his recent widowhood. She made a second attempt to tell about her abuse, this time to her therapist in the unit where she was treated. The response she got from her therapist was that the past was better left untouched because if she were to touch it, that would affect her behaviour with food and nothing would change after that because "the past is in the past."

From the second or third session, the belief that "no one is on my side" resulted from accommodating the abuse after years of helplessness in the face of unsuccessful attempts to ask for help became clear. The syndrome of accommodation to child sexual abuse (SAASI; Summit, 1983) describes a characteristic sequence of five phases: secrecy, helplessness, accommodation, late disclosure, and withdrawal, which is common in victims of chronic sexual abuse by close relatives.
The structure of submission and subjugation to life responds to accommodating the abuse and leaves a large imprint on one's inner experience of what the eating disorder is all about. The different types of abuse she suffered started early in life with bullying at school, sexual abuse, emotional abuse at home through guilt and emotional blackmail. She also talked of episodes of physical aggression in her family during her childhood, where on one occasion she asked for bread before eating and her mother, while making her feel responsible for her demanding attitude, put the bread in her mouth until she managed to make her vomit.

In the final stages of treatment, there was the abuse of power associated with the admission to the unit. She talked of episodes where she felt humiliated and disrespected, experiencing great fear and confusion, without knowing what she had done to make them take such aggressive measures. Once again, she mentioned to her family what happened to her in the hospital but, again, "nobody took her side" and nobody did anything.

Treatment Objectives

The therapist and patient were able to formulate a number of treatment objectives as guidelines for the treatment plan:

- Encourage a secure therapeutic attachment relationship to promote trust.
- Stabilize and regulate on an emotional level as well as on a nutritional level.
- Cognitive, emotional and somatic resources for regulatory work.
- Promote healthy living habits - food, sleep, social skills, day-to-day activities.
- Process the different adverse situations and traumas resulting from the abuse suffered.
- Integrate the life circumstances associated with the belief "nobody is on my side" and change it for the belief "I am on my side."

Intervention

The times in hospital took up a large piece of therapy work due to the aggressiveness of the patient's stays in hospital, the treatment she received there, and the complication of intravenous feeding as a result of her absolute refusal to eat.

In the beginning, the therapy was focused on the therapeutic relationship in order to ensure that she could experience someone who was already on her side. Through bonding, all the work was reinforced. It was of great importance to work with trust to start repairing the attachment and all the damage caused by the traumas of betrayal, humiliation, and the fear of abandonment as described throughout the collection of history.

As soon as the work in therapy started, the history of abuse came out very quickly, as the patient had been waiting for years. In the first moments, some stabilization work was done to calm the emotional pain that accompanied the abuse experiences described and the time in which they accumulated without the possibility to talk about it. Frustration and anger also arose from the disconnection from the pain, which the patient suppressed through the control of food and the various suicide attempts in order to stop the recurrent flashbacks she suffered over time, associated with situations that reminded her in one way or another of what she had experienced. The relationship of the eating disorder to the sexual abuse was obvious to the patient, she had always known it, but she had never been able to name it because she had never been given the opportunity to do so. This connected with a feeling of injustice and wasted time - a lifetime of illness that no one was going to give back to her because she had not been given the chance to be heard.

When the memories of the abuse started to pop up, the family and the other professionals dismissed the therapy as invalid, alluding once again to the fact that it was not good for her to bring out all the traumatic experiences that she had inside.

The eating disorder, which was still there, her dissociated state, her attempts at suicide were not associated with the traumas she experienced in life and she was not even allowed to talk about them.

She continued in therapy and began the work on stabilization and regulation through resources, such as “safe place,” learning to put limits, breathing, empowerment, and grounding. She learned self-regulation strategies and psychoeducation to identify the indicators of disconnection that might arise, somatic resource strategies that connected her to the present, and rooting. All of them were aimed at teaching her to use healthy strategies instead of resorting to food or food restriction as a way of regulating herself.

When stabilization was achieved, the work continued to focus on the behaviours with food. The disidentification of food as a safe haven was elaborated. The most phobic aspects of food - associated with the food she was forced to eat for years due to her eating disorder - were processed. The sensations, smells, textures, and situations associated with them, to which she reacted, made her unable to eat and cook, complicating her eating habits and impacting her on a physical, family, and social level.

Being able to determine that she was in control of the sessions, that is, how far we could or could not go, was important to her as was the fact that she was able to locate an internal place where she could say, "I think it' s been too much" or not. An attempt was made to expand her window of tolerance in working with trauma by respecting her own pace so that she would respect herself at all times in therapy. How far could she go and how far could she go before it got too much and overwhelmed her? Once the patient felt ready, work on all the traumatic events in her life began.

This intervention of elaboration of the trauma was conducted in three stages:

1. Sexual abuse: flashbacks, actual present triggers leading to abuse. The therapeutic bond as a reinforcement to feel support in telling the trauma. Resources for calmness and awareness.

Work began on sexual abuse because it was the most urgent. It constantly emerged through flashbacks and current life situations that triggered the trauma.

Situations, for example, in which she felt that people were not on her side, connected her with situations in which she wanted to tell what happened to her as a child when her mother would not listen to her and the abuse continued. Or, when the abuser was abusing her in the living room while the mother was in the kitchen and didn't do anything to help her.

A trigger was also that the therapist listened to her, which connected the patient with how unfairly she had been treated in her life. Once the work with this trauma began, all the scenes of sexual abuse came back to her. This part of the treatment had to go very slowly so as not to exceed the window of tolerance.

2. Emotional abuse: guilt, attachment, the mother's blaming and denial.

An ambivalent mother who had difficulty showing emotions and maintained a cold relationship with the patient. Life situations in which the patient was blamed and where guilt was used as a control strategy were processed as well as serious suicide attempts and associated guilt. When they wanted to control her in some way, they made her feel guilty. More importantly, guilt came much more often when she got sick because she was made solely and exclusively responsible for everything that happened to her.

The idea that she had broken her parents' lives was also addressed; messages she received which had damaged her. The most complicated part was to see how all the complex trauma she suffered was neither seen nor understood as a child or as an adult. There were moments at the table of hours of dissociative experiences in front of a plate without being able to get up.

This part of the therapy was extremely important for the patient. A large part of the problem with social skills (which was presented as a reason for consultation) was related to the experienced guilt, with all the wounding of attachment: a denying mother who dedicated herself to never validating her daughter and to turning everything she did into guilt by not assuming responsibility of any kind, neither when she was wrong, nor validating when things were right.

3. Power abuse: Very scary moments associated with being tied up in the unit, situations with the probe, disrespect, accusing her of lying and manipulation. She had to work through all that she had suffered in the unit when they tied her hands and feet, arguing that she was a dangerous person. She described how they kept her for a week experiencing extremely high levels of anxiety, staring up at the ceiling. These were painful situations for the patient because of how they connected to the sexual abuse.

This event represented another big moment of abuse and, again, her parents didn't do anything, they didn't defend her despite knowing that this unacceptable behavior was taking place.

The result of the treatment was most satisfactory. Once the complex traumas could be accessed and processed, the improvement was obvious. The patient was able to loosen control with food and the weight stabilized. The adjustment to the abuse that she was forced to endure throughout her life was repaired through trust and therapeutic bonding. The pattern of subjugation and submission that marked her lifeline as well as her relationship with others was repaired. Through therapy she learned to relate to others and to herself in a respectful way. Today she is a professional who is dedicated to the care of children with trauma and has created her own family. Her relationship with food is satisfactory although she continues to work on it.

Conclusion

This case study highlights the importance of abuse (physical, emotional, sexual, and power) in the development, maintenance, and treatment of eating disorders. During the clinical interview with this patient, specific questions were asked about the different types of abuse. It needed to be established that they took place. Questions should also be included about uncomfortable glances or behaviors that may have been annoying, aggressive, or intimidating to patients. Addressing the abuse suffered is the cornerstone in the treatment of

eating disorders while maintaining a window of emotional tolerance that determines the patient's ability to manage the work that has to be done in therapy with the different traumas associated with the abuse.

People who suffer from these disorders are often accused of lying and manipulation. This results in health professionals having a negative view of the patients. This negative view, for example, not trusting the patient on their word, being irritable or showing a difficult attitude with the patient, prevents the patient from seeing the dissociative experience as a need to disconnect from everything inside them that they have not been able to express and that they have put into their food in their different diagnostic representations of eating disorders.

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THE CHALLENGE

By: Renée Potgieter Marks

I still don't know who had the biggest internal earthquake at this sudden desert experience, the therapists or the children? The challenge to the team was to find resources, to innovate. We worked hard to do just that.

We very quickly realised that we were totally exhausted after our first week of doing online therapy and the WhatsApp group contained up to 40 messages a day from desperate, tired, exhausted therapists who were stuck in a world we could never love to be in. The reality is that the books we sent to the children to prepare them for the online training worked well and there was an element of exhilaration for some children to see us online, in our own homes. Other children

complained and struggled more with the transition, but generally therapists reported that the transition went much better than expected.

We decided to have a weekly debriefing group for all the therapists of the agency, where we could just support each other in this desert of limited human contact. These weekly sessions became our lifeline, the place we could complain, moan, share difficult sessions, cry, get help and above all were supported by a devoted group of therapists all feeling exactly the same.

The Solution

Three months later, the scenario looks very different. All the therapists have adapted - no, had to adapt. There is no longer only the Zoom screen in front of us. Some therapists have a big screen on the wall, due to the irritation to their eyes from long hours in front of the screen. There are document cameras next to the computers to display images of everything that is appearing on the empty part of the desk next to the computer. This can be toys, play-dough images, cards depicting feelings, family roles or pictures enabling the child to read a therapeutic story or book.

In some rooms there are toys all over, well organised in cupboards and shelves and others in boxes, containers and spread around the chair where the therapist sits in front of the computer. Puppets, soft toys, the brain puzzle, sand tray figurines, physical metaphors and everything which could comfortably migrate from the therapy rooms to the Zoom room in the homes of the therapists.

We have learned that there appears to be different responses of children during therapy after we started to work solely online:

- The biggest surprise was that children and adolescents who are usually doing well in therapy in the therapy room, continue to do well with online therapy.
- Children and adolescents who struggled with therapy, or who were inconsistent in their engagement in the therapy room, are doing exactly the same with the online therapy.
- The vast majority of adolescents are doing much better with online therapy than with face to face therapy. It is possible that this is the space where adolescents nowadays share their most intimate details with people they have barely met. Having the familiar or sometimes unfamiliar therapist in front of them means that the therapist finally adapts to their world and they fully engage with gusto!
- Younger children initially struggled as they missed the toys and metaphors they used. Creative parents have bought a plastic tub, painted the bottom blue, put sand in and bought sand tray toys and this fully replaced the frustration of not being able to use the sand tray.
- Younger children bring their own toys into the therapy space and they always bring with it amazing metaphors of their own life which can be used during the therapy session.
- Younger children are more in need of seeing the familiar toys of the therapist, the puppets or soft toys, animals of pictures they previously made, to help them with the transition into the therapeutic space. They even surprised us by going out of the therapy space and coming back with a replacement for toys they used in the therapy room and continued with the therapy process as if nothing changed.
- Children enjoy therapeutic stories read for them by the therapist or parent over Kindle and screen share in exactly the same way they enjoyed the reading of these therapeutic stories from books in the therapy room.
- Children can be active in movement, physical games and dancing in the therapy space in a similar way that they do in the therapy room,

although they cannot always be seen. The conversation with the therapist keeps 'holding' the child in the therapy space. Doing some of these activities with the child, also provides some exercise for the otherwise very passive therapist!

- Children are enjoying writing and drawing on the whiteboard which is a facility of Zoom screen share, exactly the same way they use pens and paper in the therapy room. And the therapist can save it immediately on the laptop to import it to the child's file.

- There are some adolescents and children who do not want to be seen. Instead of having to go and hide under a blanket or cushion, they switch off their camera and feel safer while continuing with the therapy session.

- Only a few parents and/or children totally refused to engage with online therapy. In the majority of these cases, it appeared that parents had more resistance than the child.

- EMDR/BLS is still being used. Most parents have downloaded the app which enables them to get the bilateral sounds. Many parents have connected their device to stereo speakers in the room to enable bilateral stimulation. Some children are using ear pods hanging over their ears. Some parents are tapping shoulders, feet or knees. Other children are marching up and down.

- Some children also tried to hide in the room and as most children and adolescents are seen with the parents, the parents explained to the therapists what was happening and therapy continued.

- A couple of children left the therapy space in their house; most of them returned for the rest of the session. The few children and adolescents who refused to return clearly made a significant therapeutic statement.

Of course, there has also been the very awkward moments. Seeing an adolescent in their own bedroom, without a parent present, felt very uncomfortable. If the bedroom of the child or adolescent is the only private space to conduct the therapy session, there are few options in an unknown, lockdown world. We have put some safeguarding rules in that no adolescent is seen without the parents knowing the time of the therapy session. The invitation for the online therapy session is also sent to the parents and the parents' electronic device is used. The parents were also asked to come into these sessions at least 1 to 2 times, unannounced, to check whether the adolescent is fine or needs anything to eat or drink. Of course, it never appeared that this was unusual for the adolescents who mostly start to engage in therapy as soon as the sessions started.

There have also been some extra visitors in the therapy space. For example, a sibling refusing to leave the therapy space. The therapist surrendered and completed an excellent session about sibling rivalry.

Then there was Jamie, who apparently in a different dissociative state, arrived and had no idea who was on the screen. He was furious and demanded that the parents immediately switch off the screen as he did not know this person on the screen. No amount of explanation from parents helped. Jamie was adamant, shouting and screaming. With the first moment of silence the therapist said "Hallo, I am so glad to meet you. I see you don't know me" and introduced herself to the child. Calm descended as another state arrived and consoled the new dissociative state that this is the friendly therapist who helps Jamie and the therapy session resumed.

Therapists also started to 'feel' the atmosphere in some houses. Overstressed parents were identified and many parents received more support during this period of lockdown. Therapists finally accepted that anything can happen at any time. There were some cats, dogs, hamsters and mice attending therapy as well. To get the perfect therapeutic setting in the house of a family who lives with

highly dissociative children or child, is not easy. The answer appeared to be that it is easier for the therapist to adapt the therapy than to fight the inevitable. Parents worked very hard to create a therapy space but it was not always successful, yet therapy continued. It appeared that most of the children were resolute that they would continue to use their own therapy space, notwithstanding the changes and challenges.

The initial despair of therapists also slowly made space for silent acceptance of this is life, right now. The main benefit is that the vast majority of children's therapy continued with a smooth transition from face to face therapy to online therapy within one week. Excitement reigns in every therapy support group when there is a new "gadget" or a new method or therapy tool which is shared or invented.

But, the therapists generally remain very tired and extremely exhausted at the end of each week. We quickly found that it is better to have space between sessions in order to move, drink something and recover somewhat. Continuous back to back sessions causes significant stress and exhaustion. One theme remains – we all want to go back to the therapy rooms as soon as possible. The children are starting to miss us more, the novelty is gone, but therapy continues. Some sessions had to be shortened as the 1.5 hour sessions that we usually have, became too difficult for some younger children.

Due to many children waiting for assessment, we could no longer allow them to wait and we have also started to assess children online. We all thought it was impossible, yet are finding excellent results. All parent discussions, parent groups, parent training, reviews, meetings and also family observations are done on line. It is business as usual, except that in the hearts and minds of the therapists, there remains an enormous need for the 'normal'.

The Unknown

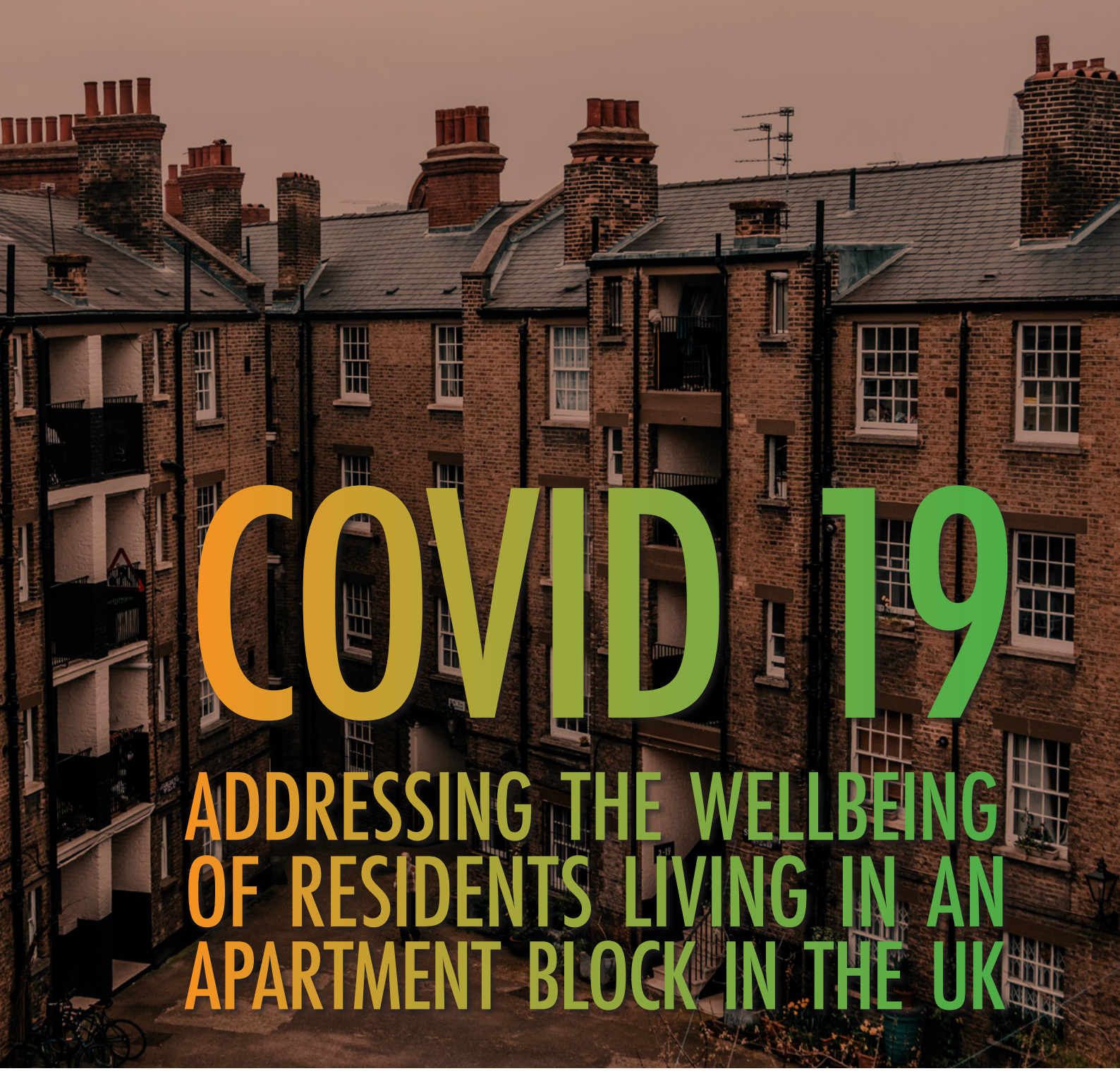
It somehow feels like we have reached the eye of the storm, we have survived the first part but are sitting with the unknown in front of us. Not because of the children, but because of the gnawing need to return to the therapy rooms, to be physically with the children and to be together again. Perhaps, we are just a species where physical 'being with' is critically important. But the unknown is equally critically frustrating. Only time will tell. There is a big group of children who are very impulsive, who will not be able to abide by the rules of social distancing. There are those who impulsively make physical contact with the therapist and the ones that love to spit. There is the reality of not being able to use the waiting room, not being able to use the sand trays, the toys, the play dough. How do we navigate that, when that was our normal life? How does the therapy room look without using what is in it? Do we hide the toys?

Then there is the problem with masks. How do you fully read the child's expressions with a face mask – that is if the child will wear a face mask which is highly unlikely in the vast majority of cases. Who will wear the mask? Surely not the therapist! The therapist is the emotional regulator of the child in the room. This does not only include eyes staring from above a mask! Or will it be better to use a screen? What is the message the child will get? What happens if the child sneezes or coughs? None of the therapists can rely on the highly dissociative child to adhere to social expectations, and will a screen stop them from accessing the therapist or will it become a challenge to break the rules. We are all looking for answers. We thought moving therapy on line was the actual challenge, but now we think the main challenge might be the journey back to the therapy rooms.

But in the meantime, therapy continues 7 days a week as usual and a big cheer for all the brave therapists who moved with the times and the shocks and adaptations to keep the therapy process for the children rolling. Trauma is still processed, attachment is still happening, dissociative states

are still revealed and worked with and integrations are still taking place!

Perhaps the biggest benefit is that therapy can now be done over much bigger distances. Families who drove for many hours to come and see us, now have the luxury of remaining at home. Children who could only be seen fortnightly can now be seen weekly. And the unreal reality is that it is highly likely that for at least the majority of adolescents and many children with complex trauma and dissociation online therapy has finally become a possibility in a world where distance no longer really matters! 



COVID 19

ADDRESSING THE WELLBEING OF RESIDENTS LIVING IN AN APARTMENT BLOCK IN THE UK

By: Valerie Sinason, Maddie Blackburn and Paul Dennison.

We are all living in a strange time as trauma workers. If we are lucky enough to live in a country that is not at war, we are experiencing the unusual situation of aiding traumatised people whilst we share being in a dangerous situation. How do we help ourselves to aid others in these circumstances? Helping to facilitate creativity and collaboration with our own neighbours and local environment provides the double benefit of improving the environment in which we all live.

This article presents an example of a model we created in a block of 72 flats in the UK. We thought our model might be of interest as the residents are diverse in terms of age, ethnicity, and socio-economic backgrounding. The block consists of second homers, renters, owner-occupiers ranging from families with babies here only just before

lockdown to older people still shielding, people self-isolating, people with life-limiting health problems, mental health problems, the bereaved, and those who were working from home.

The project began in March 2020. A retired Nightingale nurse (MB), who trained at the first Florence Nightingale School of Nursing, St Thomas' Hospital, London and is currently a University researcher working with people with life-limiting conditions, became aware of a number of residents who were experiencing COVID-19 type symptoms and felt very unwell. She (MB) recognised the need for a therapist to join her and with the support of the Board who manage the block and others, a COVID-19 advisory team (CAT) was set up. Together with the Board, they designed a strategic model that specifically focussed on the risks, impact and implications on the health and social needs of residents and then went about implementing this on an ongoing basis. This was beyond the advice provided for owners and landlords during the global pandemic.

Prior to the UK Government's "lockdown", the Board and Maintenance Team were already initiating, implementing and monitoring the health and safety risks within the building, whilst the CAT team provided physical, practical, emotional and spiritual support when required.
As the CAT members included a GP, retired nurse, psychotherapist and Editor, there was an important range of skills with which to collaborate. Together with the Board, there was a shared weekly meeting to discuss problems, steps forward and to troubleshoot. The Maintenance supervisor attended this meeting as well so ideas could be swiftly implemented.

Maintaining cleanliness in the shared areas, sharing in deliveries, sanitising hands, rulings of one person in the lift only and other posters around the building added to the social cohesion and safety of the block. There was practical support, tips for self-isolation where necessary, virtual one-to-one, in-confidence counselling and medical advice.
A WhatsApp group was started which allowed a range of thoughts and feelings and practical ideas to be expressed. Clapping for the National Health Service on a Thursday evening at 8pm allowed a feeling of being linked together with the outside world. A playing of shared music on balconies followed, as well as virtual quizzes and story-times for children.

Three newsletters were provided which included details of local support groups available for physical and mental health problems, emotional advice as well as maintenance notices regarding improvements to the block. The fact we had a professional Editor aided good design and layout! The final newsletter focussed on creative celebration of the block with poems, art, tips for survival, a 'kids corner' and news items. Here is a small extract from our first newsletter:-

Emotional First Aid

1. Acknowledge that these are different times and that stress is almost inevitable.

2. Acknowledge how much of our lives will now be different

3. Acknowledge that with a plague we are facing the possibility of death for ourselves or our loved ones

4. Acknowledge that with a plague we face the fear of contaminating or being contaminated

5. Acknowledge that the only certainty is uncertainty but that we can do our best to achieve the best goals

6. Acknowledge that cyber-intimacy is now going to temporarily supplant physical intimacy

7. Acknowledge that a percentage of those who have been unloved and deprived will not feel like protecting themselves or others

8. Acknowledge that a percentage of those who have been unloved and deprived will want to feel immortal and immune to any danger

9. Acknowledge gratitude for the freedom we have had to congregate, to shop, to walk and to visit for all the years up until now

10. Acknowledge the will for creativity and collaboration in the majority of the population.

We have received individual and group feedback that there is a greater sense of neighbourliness in the block. This has added to the feeling of emotional safety. The speed of ideas becoming implemented due to the collaboration between the Board, CAT and Maintenance Supervisor has also enhanced the sense of physical safety.

We have noted the different developmental hurdles coronavirus causes for babies, toddlers, latency children, adolescents, young adults, millennials, the middle aged, people with life-limiting conditions and the elderly and have provided psycho-education on the specific issues for each age . There have been different benefits for each age group, either shared publicly or privately.

For everyone

Sharing fears and hopes has made the block itself a home as well as the apartments within it. It has been possible to share losses, bereavements, breakups, hopes for new relationships , pregnancy and ageing .

Trauma Workers

Trauma workers require a safe internal and external home from which to offer support to those who have no internal home. At this time of coronavirus, we have three key issues to report:

1. Some survivors feel relief that "normal" people show and express fear of coronavirus and it helps them feel ordinary. "If normal people had a family like mine then they would feel like me" said one.
2. Some survivors feel their own unique trauma has been subsumed into a larger social disturbance and minimised or ignored.
3. Attachment and hope bind all of us together and can help us through this crisis.

We hope this article will help others living in similar circumstances.

IMPACT OF PHYSICAL EXERCISE ON PTSD: A REVIEW

By: Raffaele Avico

Abstract

This review intends to collect and analyse previous studies on the influence of physical activity on PTSD. Although the number of studies currently dealing with this issue is expanding, important lines of scientific research have not examined it thoroughly. This is disappointing considering the strong repercussions of PTSD on the human body, which scholars have clearly illustrated.

The following article will list and group the most relevant scientific studies on the preventative role played by regular physical exercise against the chronification of PTSD and the need to combine it with psychotherapy.

The aims of the present work are to raise sensitivity among the scientific community on the body's pivotal role when taking charge of a PTSD and to hypothesize a combined intervention through psychotherapy and daily workout.

Review: The Existing Literature

The literature in the psycho-traumatologic field reporting strict data on the impact of physical activity on PTSD is expanding, yet still scant in terms of standard protocols and detailed guidelines on what can benefit PTSD patients.

The impact of PTSD on the body is known - it has been highlighted in multiple studies published in authoritative magazines and well explained by scholars who have led the way, such as Bessel Van der Kolk in The Body Keeps The Score.

Magazines including the American Journal of Psychiatry and the Journal of Clinical Psychology, reference recent studies involving PTSD patients for whom standardised protocols of physical exercise were applied. These studies evidence the generic importance of aerobic physical activity, aimed at developing "muscle endurance," to mitigate the somatic effects of PTSD.

Main contributions, listed in chronological order:

Fetzner & Asmundson (2014) investigated the benefits of regular aerobic activity (specifically, 6 sessions of 20 minutes in two weeks, i.e. 3 weekly sessions of 20 minutes) on a sample group of 33 PTSD patients. The researchers divided the group into 3 different sub-populations: the first of these was provided, during the exercises, with a "cognitive distraction" aimed at inducing the subjects to focus on other than the exercise itself or their own bodies. The second group was given the task of focusing on interoceptive aspects (i.e., to concentrate on the inner sensations stimulated by the exercise itself). The third group was simply asked to engage in the ongoing physical activity. The aim was to understand the ways in which a standardised and regular set of exercises may impact the symptoms of an heterogeneous group of PTSD patients: in particular, the investigation on the interoceptive subgroup focused on the causes – not only the presence – of sport's benefits on PTSD. The results, however, showed few, if not no, differences, among the various subgroups. This may suggest a positive intergroup experience of aerobic exercise in the treatment of PTSD. The researchers argued that exercise in general could have enabled a process of "interoceptive exposition," i.e. have promoted an active confrontation with body sensations stimulated by physical exercise itself. As we know, one of the key strategies – if not the main one – of PTSD management is the good handling of the somatic activation triggered by the emerging trauma. In this respect, the confrontation with the somatic sensations induced by regular aerobic exercise might prove a strong act of exposure to what comes from the body, regardless how much attention is paid to it.

Rosenbaum et al. (2014) published a randomised study, in Acta Psychiatrica Scandinavica, which investigated the difference between two types of treatment (with or without physical exercise) provided to a group of 81 patients with primary PTSD (diagnosed according to the criteria of the DSM IV, excluding those cases better defined by complex trauma and those suffering from chronicle physical pathologies, both likely to spread confusion in the process of analysis). The conclusions showed a higher improvement in the conditions of those who had been treated with physical exercise (specifically, 30 weekly minutes of cardio fitness in hospital, two sessions at home and a controlled program of minimum walk – up to 10,000 steps per day – for each subject).

Vancampfort et al. (2016) carried out a review on a sample of about 1,400 people with PTSD, highlighting a correlation between hyper-arousal and physical activity. They argued that one of the benefits of physical activities for PTSD patients might lie in their very process of habituation to the states of hyper-arousal, which are in fact better tolerated and managed with regular exercise.

Wolf Mehling et al. (2017) observed, in the Journal of Clinical Psychology, how a sample of 47 veterans subjected to physical training and mindfulness-based techniques for 12 weeks had experienced a general reduction of the dysregulative effects of PTSD-typical hyper-arousal states, thus experiencing a

general improvement in their quality of life.

Vancampfort et al. (2017) published a meta-analysis carried out in five studies on a total of 192 PTSD patients, who had been treated with psychotherapeutic rehabilitation in combination with physical training. The authors evidenced the presence of certain psycho-physical benefits and reduced symptoms of hyper-arousal and avoidance, which led them to generically encourage the adoption of twice weekly resistance-training sessions together with 150 minutes of moderate exercise (or two 75 minute sessions of vigorous exercise) per week.

Oppizzi and Umberger (2018) carried out a deep meta-analysis of the pre-existing literature publishing one of the most exhaustive contributions to the research on the topic. The key points of this meta-analysis may be synthesized as follows:

a) higher impact of aerobic activity – such as brisk walking, rope skipping, jogging, cycling – on PTSD;
b) increasing evidence of the significant benefits of Yoga practice on PTSD symptoms;

c) importance of constant physical training and

d) centrality of sleep quality, which is improved by physical activity, as a therapeutic element in relation to PTSD.

Furthermore, some hypotheses were made about the mechanisms underlying the benefits of physical exercise on PTSD:

a) expositive hypothesis - some reasoned exercise would allow PTSD patients to slowly familiarize themselves with the somatic sensations triggered by traumatic experiences;

b) regulative hypothesis - exercise would help to decrease the hyper-arousal states and escape the hypo-arousal ones and

c) physiological hypothesis - regulation of the hormones released by post- traumatic stress, liberation of endorphins, increased brain neurotrophic factor.

Hegberg et al. (2019) exhaustively examined 19 studies carried out on PTSD-diagnosed subjects. This explored the correlation between the use of aerobic exercise only (thus excluding Yoga and other practices) and PTSD levels. The results showed evident links between aerobic activity and decreased PTSD symptoms; nonetheless, the authors called for further research (namely RCT studies) in order to evaluate a possible causality between the two events. This article sets a series of hypotheses about the mechanisms of action of physical exercise in terms of benefits for PTSD.

Specifically, the authors mention:

- desensitization and exposure: A subject exposed to aerobic (including vigorous) exercise stimulating an hyper-arousal condition is likely to interpret that very physiological alteration as non-pathological in context of non-exercise (for instance, in case of an intense tachycardia due to vigorous exercise, that very tachycardia will be ideally interpreted as less "dangerous" also in daily life);

- cognitive impairment: The authors noted the absence of studies relating physical exercise and better cognitive performances in subjects suffering from PTSD. However, a vast quantity of studies about improvement of some cognitive functions in the elderly and the young (in particular executive functions and episodic memory) suggested that the same improvements could be detected in PTSD patients, Those very cognitive functions – episodic memory and executive functions – being the most compromised in the PTSD; anatomic functions and altered brain structures: Here also the authors evidenced the absence, upon publication, of studies examining the morphology (altered or not) of specific brain areas following a period of specific training. However, they noted that various studies

showed a positive impact of aerobic exercise and "cardio-respiratory fitness" on the morphology of many brain areas in elderly patients – the same areas which are altered following the development of PTSD;

- hypothalamus-pituitary-adrenal axis (HPA): Studies on healthy subjects show how physical activity helps keep HPA functioning. The authors suggest that physical activity could benefit HPA regulation in PTSD patients. In this population, in fact, the impact of post-traumatic stress on the HPA circuit, due to an alteration of its feedback mechanism, had been observed.The authors pointed out that the studies on the HPA axis in correlation with PTSD are too scarce to provide reliable data. Finally, the authors observed how multiple sources referred to the correlation between alterations of the immune system and the presence of prolonged stress, in particular in relation to the concept of inflammation. The de-inflammatory effects of physical activity and its beneficial effects on various aspects of life, including sleep quality, are well documented in literature. The authors noted the core importance of sleep in the recovery from PTSD as a significant processing of the mnestic data (cognitivization) takes place during sleep. (Pagani et al., 2017)

Neurocognitive and neurophysiological aspects: some speculative assumptions

The work of Hegberg et al. represents the most exhaustive contribution in literature so far. In general terms there are different theories regarding the mechanisms which make aerobic physical activity a potential for integration to the standard treatment of PTSD. These theories are attributable to four hypotheses.

1. Auto-regulation

Using the body for regulatory purposes can be considered a mastery strategy, meaning an active behaviour promoting the recovery of mastery status in terms of emotional regulation. There are different ways to recover the mastery. The body represents an often effective, although primal, way to fall into line with what Daniel Siegel calls the "window of tolerance." Physical activity creates the ability to soothe states of neurophysiological dysregulation when these are excessively upward in tendency (hyper-arousal) or to promote a "return to life" against states of seemingly invincible de-activation (hypo-arousal). It is understood that PTSD determines dysregulations of both hyper and hypo-arousal.

2. The body dissipates the trauma

This expression, borrowed from one of the world leaders in the somatic approach to trauma, Peter Levine, expresses the sense of letting the traumatic experience out through the body. The studies of Pat Ogden focus on the development and the practice of "action tendencies" blocked during and after trauma. Levine carried out long studies on animal behaviour looking at trauma in both an aneural-biological and ethological sense.

Animals, when not marked by past traumatic experiences, respond effectively to single traumas by "shaking" them off their bodies, thus restoring the pre-trauma neuro-physiological state. Humans are not always able to do so. Despite the substantial inter-specific overlapping of the oldest brain parts observable in vertebrate animals, the human brain is equipped with some powerful tools of storage and problem solving regarding experienced reality, which paradoxically leads to an excessive and distorted storage of the trauma itself. Levine speaks about an excess of physical "energy" which, unable to develop in a biological sense because of the state of deep impotence experienced during the trauma, remains in the body perturbing it (post-traumatic stress). This aspect of Levine's theory precedes and is comparable to the already mentioned "action tendencies" theorized by Pat Ogden, which should ideally be "taken out" through sensorimotor channels, i.e. through the body (first vehicle and natural site of the escape/attack reactions triggered by threats), with some semantic nuances. (Pat Ogden defines the action tendencies as a highly finalized movement, Levine as a "too full" that must be let out.) Sport, in this respect, might be conceived as a vehicle for letting out the action tendencies matured during trauma. Levine describes somatic effects of PTSD reactions as including tremors, excessive sweating and cold hands. According to him, such signs might tell us about an autonomous response of the central nervous system, blocked in an abnormal,

prolonged "defence mode" as if expecting a new hypothetically forthcoming traumatic event. Levine, together with other scholars, interprets these signs and symptoms as bodily "spies" of something that needs to be evacuated or dissipated (e.g. an intense anger left unexpressed, an impossible escape from the body).

For example, when observing an animal emerging from a state of apparent death, we can see that the animal evacuates the state by means of trembling. Some animals – for example bears – tend to tremble more (they are shaken by intense tremors which then quiet down), others less. Tremor represents a natural response aimed at dissipating terror and anxiety with some psychotherapeutic schools of thought seeing its voluntary self-induction as an instrument to discharge the energies. The "discharge of fear" process following a strong shock or trauma seems, in fact, to naturally occur. We know that animal behaviour recapitulates, in a certain simplified sense, our own behaviour, and that sometimes we can learn from the observation of animals, that which we hardly manage to observe in ourselves. The work done by Peter Levine teaches us that the body must be "discharged" following a strong activation. Sport, in this respect, provides an ideal and modular container to successfully express such blocked tendencies.

The image above describes an ideal sequence which illustrates immobility to recovery of empowerment conditions through running. The running tool is used as a means for the development and achievement of the fight-or-flight response which was kept frozen by the trauma. Levine effectively explains how, in order for a trauma to settle, there must be an association between immobility and fear in order to dissociate and solve, in a clinical sense, these two aspects of the patient's life experience to free him from the trap of the post-trauma.

3) Interoceptive exposure therapy

Exposure therapy is founded on the concept of rehearsal, i.e. repetition and habituation, which makes it an effective coping tool in those cases where the tendency would instead be "avoiding". Rehearsing a public speech, attending places perceived as dangerous, indulging in the reading of inner states of fear and terror, are all examples of exposure strategies used to make those very stimuli (both inner and outer) less "activating".

One of the consequences of PTSD is the continued inner and outer avoidance of all that concerns the trauma and the context in which it took place. The expression "phobia of interior states" is used to indicate the result of an individual's total avoidance of that which might elicit a dysregulated body reactivation (inner triggers such as thoughts and images able to provoke a traumatic break-in are avoided). According to this hypothesis, physical activity would allow the re-appropriation of a higher sense of control, through exposure and habituation, on the bodily sensations induced by regular exercise.

4) Antidepressant and anxiolytic effect of physical exercise

Multiple studies have valued and shown the positive impact of physical exercise on symptoms of depression and anxiety stemming from various life experiences. If we consider the "network" theory of mental disturbance promoted by Denny Borsboom, psycho-pathological symptoms are to be considered as horizontally located on the individual's psychological scene, connected and interdependent. We can also see an indirect impact of physical activity on PTSD, including its impact on some of the side symptoms of post-traumatic stress itself, such as severe insomnia or general anxiety. In fact, the cognitive performances of a PTSD patient coping with the management of the disturbance generally improves with the improvement of sleep quality. It must be remembered that post-traumatic stress feeds on the constant adaptation to a reality which is perceived as threatening. To face it in a state of prostration from lack of sleep makes it even more threatening (Pierre Janet has described it as easier for a potentially traumatic event to take root in the mind of its victim in conditions of "psychic tiredness"). The same could be said about depressive experiences resulting from exhaustion. Regulating imbalances or decreases in mood by stimulating the production of endorphins through a prolonged

session of aerobic exercise should be considered an attempt to generally improve life quality in the goal of liberation from primary PTSD.

Conclusions

The present review follows on from previous articles aimed at evidencing how the bodily channel can affect some core neuro-physiologic and somatic symptoms of PTSD. A reasoned use of a specific workout program, combined with triphasic psychotherapy, could accelerate the recovery time and induce a higher sense of grounding, stability and mastery. It has not been possible here, due to lack of resources, to undertake an in vivo trial path of the suggested training program on a suitable sample of subjects. I hope it will be undertaken in the future by experts interested in the topic. Ideally, research into PTSD would benefit from experts in athletic training specialized in the treatment of PTSD, who could merge with a specialist team – together with psychotherapists and psychiatrists – able to act in parallel.

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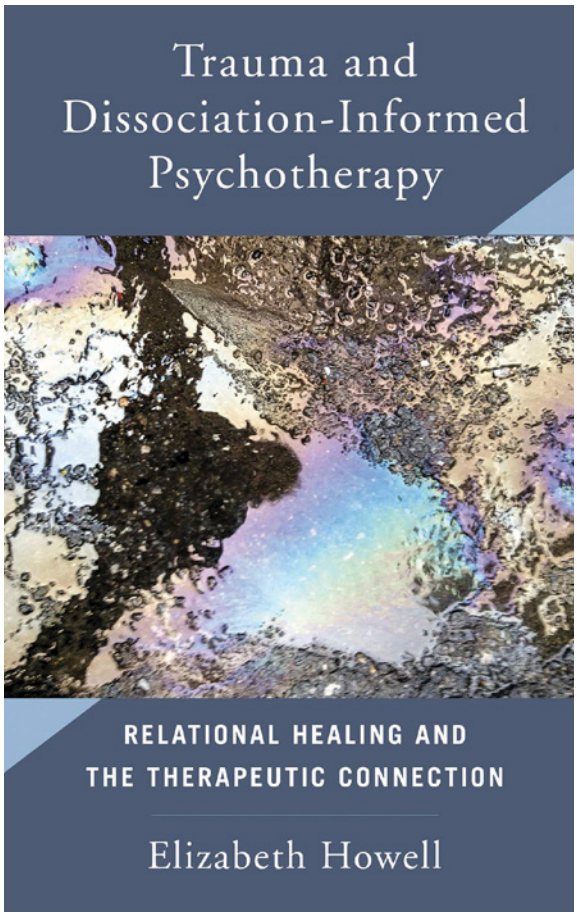
Book review by: Nancy Fair

TRAUMA AND DISSOCIATION INFORMED PSYCHOTHERAPY:

Relational Healing and Therapeutic Connection.

By Elizabeth Howell, W. W. Norton & Co., Inc., 2020, 232 pp., ISBN: 9780393713732



Elizabeth Howell's new book arrived in my mailbox just weeks after the viral pandemic known as COVID-19 began to engulf the world, killing and sickening millions as I write this review, and the viral threat continues to loom. Shortly thereafter, on May 25, an unarmed Black man named George Floyd was brutally killed by Minneapolis, Minnesota USA police, all of which was caught on film by bystanders. The resultant outrage has become known as the movement, Black Lives Matter, and, like the pandemic, has been taken up worldwide as populations on all continents protest police brutality against people of color. To say that Dr. Howell's book arrived in a timely fashion is a serious understatement, but timely it is in several ways that bear a more in-depth look in this time of universal trauma of multiple varieties.

Dr. Howell, who trained as a psychoanalyst in the 1970s, describes her awakening to the ubiquity of trauma and dissociation as causes of human distress after becoming fascinated by the books and articles being written in the 1990s by some of the pioneering authors in the trauma field. After having taught Freudian theory to students, Dr. Howell realized that trauma literature made much more sense of human distress than the Freudian theories she was teaching. Chapter 1 of the book describes how Freud's burial of trauma in favor of Oedipal theory resulted in, as Howell eloquently states, "(1)…the widespread theoretical and cultural denial of real-life, exogenous trauma in psychoanalysis and the culture at large, and (2) the consequent suffering of many human beings who remained confused about or disbelieved their own experience." (p. xix). Dr. Howell's context here refers to the damage caused by societal denial of childhood abuse, but the denial of exogenous trauma of which she speaks applies as well to the ongoing global struggles with the deadly pandemic and widespread "theoretical and cultural denial" of systemic abuse of people of color and other marginalized populations.

In Chapter 2, Dr. Howell describes trauma as "that which causes dissociation," and how trauma that is early, chronic and severe affects our capacity for regulating affect and for relating to others; the treatment for which is addressed in Chapter 3.

Chapter 3 begins with the ubiquity of trauma and dissociation – its embeddedness in human existence- removing any reader doubt as to whether or not trauma therapy should be viewed as a "specialty practice" as I heard it labeled in my graduate program. Chapter 3 also explains the respective differences and values of "top-down" (verbal/cognitive) therapies versus "bottom-up" (sensorimotor/bodily and affective) processing in addressing trauma. Of particular relevance in this chapter is a discussion of the Adverse Childhood Experiences (ACEs) and the effects of specific childhood life events on long-term adult functioning, which affects individuals' capacity for navigating the ongoing, immersive trauma we are currently experiencing.

In Chapter 4, Dr. Howell addresses individual psychotherapy as a "wounded dyad;" a 2-person dialogue, and a concept that runs counter to the implicit Us-Them (healthy therapist-wounded client) dichotomy many of us have encountered in our training, or within hospital psychiatric systems that assume a doctor is treating a person with a disease. A clinical vignette from Dr. Howell's practice illustrates how she and her client work through an incident of "mutual dissociation" within their therapy dyad.

Chapter 5 addresses the terms dissociation, repression, and the unconscious, how they are sometimes used interchangeably, and how we might think of their use in talking about trauma and dissociation. This chapter also introduces the concept of dissociative structure, how it works, and how it can be worked with in therapy. Dr. Howell introduces the concept of working with dissociation from the "inside out" versus the "outside in," which compares the benefits of working from an understanding of consciousness as multiple rather than unified.

Chapters 6 and 7 deal with the effects of attachment dilemmas, especially disorganized attachment, on the wounded child and her efforts to create behavioral systems that allow her to endure an overwhelming environment. Chapter 7 specifically delineates the various ways in which disorganized attachment contributes toward personality organizational systems that may be somewhat effective in childhood, but that may become problematic in adulthood. This chapter illustrates the wide variety of adult problems that can arise from attachment patterns, and that undoubtedly affect the functioning of society as a whole.

In Chapter 8, structural models of the dissociated psyche are explained, with common aspects being the organization of these models around traumatic experiences and their sense of distinct autobiographical selves. The concept of structural models of the psyche ties in with Dr. Howell's Chapter 5 description of working with dissociation from the inside out.

The trauma and dissociation experienced as a result of childhood wounding create a closed system within the individual in which, as Dr. Howell states, "…internal dividedness replicates the external interpersonal distance between the client and early attachment figures." (p. xxi).
Chapter 9 describes the work that we face as therapists, which is to help our clients learn to relate to others, and to the disowned aspects of themselves, as a way out of the closed system in which they are trapped.

The concluding chapter of the book compares the myth of Osiris to that of Oedipus, noting that Freud left out a critical part of the story when he selected the story of Oedipus to represent his theory of childhood development as fantasy. I will not reveal the missing piece of the story here – readers are invited to read the book to find out, but Chapter 10 explains how the myth of Osiris is a far better symbol for the work of healing trauma and dissociation – namely, one that represents the piecing together of our wounded selves.

Those of us who are most likely to read Dr. Howell's book are psychotherapists who work with traumatized populations, and I highly recommend the book for new therapists, for obvious reasons,

and for the more experienced who might value the comprehensive presentation of the trauma field's most crucial concepts. The clinical vignettes in the book provide real life examples of how trauma work happens, and for readers who desire to delve more deeply into the details of a specific topical area, the references are plentiful.

In Summary, Dr. Howell's book is a timely addition to the literature in that it synthesizes, in exquisitely readable language, the most recent theoretical developments with the most humane and effective approaches to healing trauma and dissociation. I have been engaged in doing trauma work for 25 years and appreciate seeing the contributions of many of the best minds in the field, some of whom I know, but all of whom I know OF, brought together in this volume. It is a book for our times in that the principles it contains apply to individual client work, and to the work that faces us on a societal level as we contemplate the healing needed by our traumatized world.

HOT OFF THE PRESS

By: Winja Buss

Introducing the latest research

Dear Readers, again, here comes the latest research on trauma and dissociation and related fields for your science-hungry brains and hearts... As is true for all research: regard these studies with great care and a critical mind – they deserve it!

The Pandemic Paradox: The consequences of COVID- 19 on domestic violence

Bradbury–Jones, C., & Isham, L.

COVID–19 (the new strain of coronavirus) has been declared a global pandemic. Measures announced over recent weeks to tackle it have seen people's day–to–day life drastically altered. These changes are essential to beat coronavirus and protect health systems (UK Home Office, 2020). However, there are unintended, negative consequences. As the virus continues to spread across the world, it brings with it multiple new stresses, including physical and psychological health risks, isolation and loneliness, the closure of many schools and businesses, economic vulnerability and job losses. Through all of that, children and their mothers are particularly vulnerable (End Violence against Children, 2020) to the risk of domestic violence. Domestic violence refers to a range of violations that happen within a domestic space. It is a broad term that encompasses intimate partner violence (IPV), a form of abuse that is perpetrated by a current or ex–partner. In this editorial, we talk about "domestic violence" because this is the term used most often in the media. It is important to clarify though that we are mainly referring to IPV and its impact on children who live with or are exposed to IPV between adults. We also focus mainly on women, because they are disproportionately affected by domestic violence; however, we recognise that domestic abuse happens to men and occurs within same–sex relationships.

Bradbury–Jones, C., & Isham, L. (2020). The pandemic paradox: The consequences of COVID–19 on domestic violence. Journal of clinical nursing. [retrieved 07/01/2020]: https://onlinelibrary.wiley.com/doi/full/10.1111/jocn.15296

COVID-19 and Refugee and Immigrant Youth: A community-based mental health perspective.

Endale, T., St Jean, N., & Birman, D.

In this article, we comment on the experience of the Kovler Center Child Trauma Program (KCCTP) following the March 21, 2020, shelter at home order in Chicago due to COVID-19. The KCCTP is a program of Heartland Alliance International that was founded in 2018 to provide community-based mental health and social services to immigrant and refugee youth and families who have experienced trauma. COVID-19 temporarily closed the doors of the center, suspending provision of in-person services in the community, and the program was forced to become remote overnight. The KCCTP rapidly transitioned to providing accessible information, active outreach, extensive case management, and flexible delivery of teletherapy and online psychosocial support, finding that attending to structural barriers and basic needs was crucial to family engagement and therapeutic success. Ongoing challenges include technological proficiency and access to computers, Internet, and private spaces.

Endale, T., St Jean, N., & Birman, D. (2020). COVID-19 and refugee and immigrant youth: A community-based mental health perspective. Psychological Trauma: Theory, Research, Practice and Policy. [retrieved 07/01/2020]: https://europepmc.org/article/med/32478552

Teleanalytic Therapy in the Era of Covid-19: Dissociation in the Countertransference

Svenson, K.

While we and our patients have many transferences to the modality of video or telephone therapy, these meanings are ultimately not intrinsic to the medium itself. Rather, they are symbolic meanings we make of the modality. This paper discusses the symbolic meanings that we attribute to teletherapy and the ways we may use these attributed meanings to dissociate the trauma of Covid-19. It also explores the clinical opportunities in identifying these dissociated countertransferential experiences and embodying them in our own and our patients' experiences.

Svenson, K. (2020). Teleanalytic Therapy in the Era of Covid-19: Dissociation in the Countertransference. Journal of the American Psychoanalytic Association, 0003065120938772. [retrieved 07/01/2020]: https://journals.sagepub.com/doi/abs/10.1177/0003065120938772

From Individual to Social Trauma: Sources of Everyday Trauma in Italy, the US and UK during the COVID-19 Pandemic

Masiero, M., Mazzocco, K., Harnois, C., Cropley, M., & Pravettoni, G

The heterogeneity of COVID-19 experience and response for each individual is irrefutable; nevertheless, similarities can be observed between countries with respect to people's psychological responses. The main aim of this Commentary is to provide a cultural perspective of the sources of trauma, at the individual and social level, in three different countries: Italy, US and UK. The evidence from previous outbreaks, such as SARS, H1N1 flu, Ebola, and the ongoing Italian, the US and the UK experience of COVID-19 shows that COVID-19 has introduced not only an individual trauma, but also a collective trauma, that researchers should attend to now and in future global emergencies. Future clinical interventions should aim to reconnect dissociated parts both in the individual and in society. This commentary discusses four potential sources of trauma: high-stakes decision fatigue in healthcare professionals, traumatic grief and bereavement in people who have lost loved ones, loss of roles and identity, and social divisions related to economic shutdown.

Masiero, M., Mazzocco, K., Harnois, C., Cropley, M., & Pravettoni, G. (2020). From Individual to Social Trauma: Sources of Everyday Trauma in Italy, the US and UK during the COVID-19 Pandemic. Journal of Trauma and Dissociation. [retrieved 07/01/2020]: http://epubs.surrey.ac.uk/858054/

Heightened risk of Child Maltreatment Amid the COVID-19 Pandemic can Exacerbate Mental Health Problems for the Next Generation

Cuartas, J.

The spread of the COVID-19 disrupted ecological systems in which children develop, exacerbating threats to their safety and increasing their vulnerability to future psychopathology. Supports to reduce sources of stress for caregivers and protect children from threats to their safety are warranted.

Cuartas, J. (2020). Heightened risk of child maltreatment amid the COVID-19 pandemic can exacerbate mental health problems for the next generation. Psychological trauma: theory, research, practice, and policy. [retrieved 07/01/2020]: https://psycnet.apa.org/doiLanding?doi=10.1037%2Ftra0000597

Trauma-spectrum Symptoms Among the Italian General Population in the Time of the COVID-19 Outbreak

Rossi, R., Socci, V., Talevi, D., Niolu, C., Pacitti, F., Di Marco, A., ... & Olff, M.

Background: Recent evidence showed substantial negative mental health outcomes associated with the current COVID-19 pandemic, including trauma-related symptoms although the effects on the Italian population who were subjected to unprecedented nationwide lockdown measure remains unknown. The Global Psychotrauma Screen (GPS) is a brief instrument designed to assess a broad range of trauma-related symptoms with no available validation in the Italian population. Aims: This study aimed at examining the factor structure of the Italian version of the GPS in a general population sample exposed to the COVID-19 pandemic and at evaluating trauma-related symptoms in the Italian population in the context of specific COVID-19 related risk factors associated with the implementation of lockdown measures and social distancing. Methods: Cross-sectional web-based observational study, as part of a long-term monitoring programme of mental health outcomes in the general population. 18147 participants completed a self-report online questionnaire to collect key demographic data and to evaluate trauma-related symptoms using the GPS, PHQ-9, GAD-7, ISI and PSS. Validation analyses included both exploratory and confirmatory factor analysis, and correlation analyses. Results: Exploratory factor analyses supported both a two-factor and a three-factor model. Confirmatory factor analysis showed that a one-factor solution that was used as a baseline comparison showed acceptable fit indices, the two-factor solution showed good fit indices, but the best fitting model was a three-factor solution, with Negative Affect (symptoms of depressed mood, anxiety, irritability), core Post-traumatic Stress Symptoms (PTSS) (avoidance, re-experiencing, hyperarousal and insomnia) and Dissociative symptoms. GPS Risk factors as well as specific COVID-19 related stressful events, were associated with GPS total as well as the three factor scores. Conclusions: Our data suggest that a wide range of trauma-spectrum symptoms were reported by a large Italian sample during the COVID-19 pandemic. The GPS symptoms clustered best in three factors: Negative Affect symptoms, Core PTSS, and Dissociative symptoms. In particular high rates of core PTSS and negative affect symptoms were associated with the COVID-19 pandemic in Italy and should be routinely assessed in clinical practice.

Rossi, R., Socci, V., Talevi, D., Niolu, C., Pacitti, F., Di Marco, A., ... & Olff, M. (2020). Trauma-spectrum symptoms among the Italian general population in the time of the COVID-19 outbreak. medRxiv. [retrieved 07/01/2020]: https://www.medrxiv.org/content/10.1101/2020.06.01.20118935v1

Child Victim Services in the Time of COVID-19: New Challenges and Innovative Solutions

Posick, C., Schueths, A. A., Christian, C., Grubb, J. A., & Christian, S. E.

The impact of COVID-19 has been felt by all facets of the criminal justice system and victim services agencies. The ability to monitor and report maltreatment has been severely limited for organizations that work with children of abuse and neglect; this is particularly troubling given that abuse and neglect are likely to rise during times of distress and turmoil. The purpose of this paper is to discuss the importance of organizations that work with children exposed to maltreatment, highlight the novel approach of Child Advocacy Services, SEGA, Inc. (CASSEGA), the sponsoring agency for Court Appointed Special Advocates (CASA) and the Ogeechee Visitation Centers, in rural southeast Georgia and how the COVID-19 pandemic has challenged this work, and develop strategies that can be put into place to alleviate these challenges for other child-serving organizations.

Posick, C., Schueths, A. A., Christian, C., Grubb, J. A., & Christian, S. E. (2020). Child Victim Services in the Time of COVID-19: New Challenges and Innovative Solutions. American Journal of Criminal Justice, 1-10. [retrieved 07/01/2020]: https://link.springer.com/article/10.1007/s12103-020-09543-3

The Mental Health Consequences of COVID-19 and Physical Distancing - The Need for Prevention and Early Intervention

Galea, S., Merchant, R. M., & Lurie, N.

Since the first case of a novel coronavirus disease 2019 (COVID-19) was diagnosed in December 2019, it has swept across the world and galvanized global action. This has brought unprecedented efforts to institute the practice of physical distancing (called in most cases "social distancing") in countries all over the world, resulting in changes in national behavioral patterns and shutdowns of usual day-to-day functioning.

While these steps may be critical to mitigate the spread of this disease, they will undoubtedly have consequences for mental health and well-being in both the short and long term. These consequences are of sufficient importance that immediate efforts focused on prevention and direct intervention are needed to address the impact of the outbreak on individual and population level mental health.

Galea, S., Merchant, R. M., & Lurie, N. (2020). The mental health consequences of COVID-19 and physical distancing: The need for prevention and early intervention. JAMA internal medicine, 180(6), 817-818. [retrieved 07/01/2020]: https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2764404

The Novel Coronavirus (COVID-19): Theoretical and Practical Perspectives on Children, Women and Sex Trafficking

Asongu, S., Usman, U., & Vo, X. V.

The novel Coronavirus has spread internationally to more than two hundred countries and territories. At the same time, human trafficking in girls and women constitutes a global oppression in virtually all nations either as the source, transit, or destination. The feminist investigators have it that women are in destitute situations, which is a substantial trait of exploitation, especially in the light of the present COVID-19 pandemic. There is practically no research on the relevance of the current deadly respiratory disease to human trafficking from the gender dimension. This study fills the identified gap by providing theoretical and practical perspectives on children, women, and sex trafficking. It is a qualitative inquiry that employs process tracing as a primary research instrument. To better understand the present plague and gender situation, secondary data which are utilized, consist of articles, books, reports, and integrated statistics. This research is arguably the first attempt that creates data evidence connecting the pandemic to female sexual exploitation. The paper illustrates that a policy is needed that will strengthen the capacity of existing structures in the fight against the underlying trafficking so that these attendant structures efficiently react to the corresponding threats to public health safety as well as contribute towards stopping the trafficking of girls and women during a pandemic.

Asongu, S., Usman, U., & Vo, X. V. (2020). The Novel Coronavirus (Covid-19): Theoretical and practical perspectives on children, women and sex trafficking. Women and Sex Trafficking (June 26, 2020). [retrieved 07/01/2020]: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3636386

Adolescents' Prosocial Experiences During the COVID-19 Pandemic: Associations with Mental Health and Community Attachments

Alvis, L., Shook, N., & Oosterhoff, B.

This study examined adolescents' prosocial experiences as both actors and recipients during COVID-19 and assessed whether these experiences were associated with their mental health and community attachments. Adolescents (N=437; 78% female) were recruited across the US using social media and reported on their COVID-19 prosocial experiences (giving, receiving help), mental health (depressive symptoms, anxiety symptoms, burdensomeness, belongingness), and community attachments (social responsibility, social trust, self-interest). Greater engagement in COVID-19 prosocial behavior was associated with greater anxiety symptoms, burdensomeness, and social responsibility. Receiving more COVID-19 help was associated with lower depressive symptoms and higher belongingness, social trust, and self-interest. Findings highlight the importance of furthering our understanding of these connections in adolescence to help inform post-pandemic recovery and relief efforts.

Alvis, L., Shook, N., & Oosterhoff, B. (2020). Adolescents' prosocial experiences during the covid-19 pandemic: Associations with mental health and community attachments. [retrieved 07/01/2020]: https://psyarxiv.com/2s73n

COVID-19 and Pet Attachment

Shibli, N., Rehman, A., & Kiran, A.

Pet-attachment among the pet owners (total 91) who were admitted in a government hospital for COVID-19 was studied in two wards, one ward was for patients with mild symptoms and other ward was for moderate symptoms. The researcher talked to the patients on intercom from where she could see them also and asked two questions from them, do you have a pet, yes or no and do you miss your pet, very strongly, strongly, sometimes, occasionally, and never? It was assumed that the pet attachment may vary due to the nature of symptoms and related ailment stress among pet owners in the two wards? The findings revealed that pet owners remembered possession of their pets similarly($r=.012$, $p< .001$) in both wards($r=-.016$, $p<.001$) with strongly correlated remembering. It emerged that stressful situations do not affect pet attachment and pet attachment continues in mild and moderate levels of stress. The study provided useful information about pet-attachment in stressful situations.

Shibli, N., Rehman, A., & Kiran, A. (2020). COVID-19 and Pet Attachment. Preprint [retrieved 07/01/2020]: https://advance.sagepub.com/articles/preprint/COVID-19_and_Pet_Attachment/12509366

Associations Between Trauma Exposure, Posttraumatic Stress Disorder, and Aggression Perpetrated by Women: A Meta–Analysis

Augsburger, M., & Maercker, A.

Previous research has indicated a link between trauma, posttraumatic stress disorder (PTSD), and aggression. The aim of this meta–analysis was to integrate previous findings with a focus on women. Six databases were searched for peer–reviewed articles. Random–effects models and meta–regressions were calculated. $K = 15$ studies were included, indicating small to medium effects (Cohen's $d = 0.44$ for traumatic events and $d = 0.60$ for PTSD). For traumatic events, timing effects were found. Methodological differences in types of summary statistics used in the studies yielded significant results. These findings provide further evidence for important associations between traumatic stress and the risk of aggression in women. Considering the devastating impact that this violence can have on an entire community, early interventions are key.

Augsburger, M., & Maercker, A. (2020). Associations between trauma exposure, posttraumatic stress disorder, and aggression perpetrated by women. A meta–analysis. Clinical Psychology: Science and Practice, 27(1), e12322. [retrieved 07/01/2020]: https://onlinelibrary.wiley.com/doi/abs/10.1111/cpsp.12322

Affective Temperament, Attachment Style, and the Psychological Impact of the COVID-19 Outbreak: An Early Report on the Italian General Population

Moccia, L., Janiri, D., Pepe, M., Dattoli, L., Molinaro, M., De Martin, V., ... & Di Nicola, M.

The outbreak of COVID-19 is severely affecting mental health worldwide, although individual response may vary. This study aims to investigate the psychological distress perceived by the Italian general population during the early phase of the COVID-19 pandemic, and to analyze affective temperament and adult attachment styles as potential mediators. Through an online survey, we collected sociodemographic and lockdown-related information and evaluated distress, temperament, and attachment using the Kessler 10 Psychological Distress Scale (K10), the Temperament Evaluation of Memphis, Pisa, Paris and San Diego-Autoquestionnaire short version (TEMPS-A) and the Attachment Style Questionnaire (ASQ).

In our sample (n = 500), 62% of the individuals reported no likelihood of psychological distress, whereas 19.4% and 18.6% displayed mild and moderate-to-severe likelihood. Cyclothymic (OR: 1.24; $p < 0.001$), depressive (OR: 1.52; $p < 0.001$) and anxious (OR: 1.58; $p = 0.002$) temperaments, and the ASQ "Need for approval" (OR: 1.08; $p = 0.01$) were risk factors for moderate-to-severe psychological distress compared to no distress, while the ASQ "Confidence" (OR: 0.89; $p = 0.002$) and "Discomfort with closeness" were protective (OR: 0.92; $p = 0.001$). Cyclothymic (OR: 1.17; $p = 0.008$) and depressive (OR: 1.32; $p = 0.003$) temperaments resulted as risk factors in subjects with moderate-to-severe psychological distress compared to mild distress, while the ASQ "Confidence" (OR: 0.92; $p = 0.039$) and "Discomfort with closeness" (OR: 0.94; $p = 0.023$) were protective.

Our data indicated that a relevant rate of individuals may have experienced psychological distress following the COVID-19 outbreak. Specific affective temperament and attachment features predict the extent of mental health burden. To the best of our knowledge, these are the first data available on the psychological impact of the early phase of the COVID-19 pandemic on a sizable sample of the Italian population. Moreover, our study is the first to investigate temperament and attachment characteristics in the psychological response to the ongoing pandemic. Our results provide further insight into developing targeted intervention strategies.

Moccia, L., Janiri, D., Pepe, M., Dattoli, L., Molinaro, M., De Martin, V., ... & Di Nicola, M. (2020). Affective temperament, attachment style, and the psychological impact of the COVID-19 outbreak: an early report on the Italian general population. Brain, behavior, and immunity. [retrieved 07/01/2020]: https://www.sciencedirect.com/science/article/pii/S0889159120305869

Commentary on "Associations Between Trauma Exposure, PTSD, and Aggression Perpetrated by Women: A Meta–Analysis".

Dillon, K. H., Elbogen, E. B., & Beckham, J. C.

Comments on an article by M. Augsburger & A. Maercker (see record 2020-05758-001). This meta-analysis of 15 studies examined the relationships between aggression and trauma exposure (eight studies) as well as symptoms of posttraumatic stress disorder (PTSD; 11 studies) in women. Although prior meta-analytic research has demonstrated that trauma exposure and PTSD are associated with aggression, gender differences have not been examined. In their analyses, Augsburger and Maercker found a small effect size (d = 0.44) for the association between traumatic events and aggression, and a medium effect size (d = 0.60) for the association between PTSD and aggression. The authors present these findings as providing support for identifying women who are at risk of behaving aggressively with the aim of clinicians engaging in early intervention. We agree this is an important goal, but several points need to be considered when interpreting results from the meta-analysis. First, the effect sizes were all in the small-to-medium range, suggesting modest associations. Second, methodological constraints within many of the studies that were included in the meta-analysis need to be considered and discussed. Third, because the timing of assessments was variable across studies in the meta-analyses, results need to be interpreted cautiously. Fourth, several statements in the paper could risk stigmatizing women with PTSD. Overall, despite these concerns, the findings of Augsburger and Maercker's meta-analysis suggested that there are associations between trauma exposure/PTSD and aggression that need to be better understood. One important variable missing in the studies is the assessment of anger. This meta-analysis takes an important first step, and future research should compare men and women trauma survivors to determine whether and how, as well as the temporal relationships between trauma exposure, PTSD, anger, and aggression operate differently.

Dillon, K. H., Elbogen, E. B., & Beckham, J. C. (2020). Commentary on" Associations between trauma exposure, PTSD, and aggression perpetrated by women. A meta–analysis". [retrieved 07/01/2020]: https://psycnet.apa.org/record/2020-19765-001

Posttraumatic Stress Disorder, Intimate Partner Violence, and Trauma-Informed Intervention

Gilbar, O., Gnall, K. E., Cole, H. E., & Taft, C. T.

Posttraumatic stress disorder (PTSD) has been associated with intimate partner violence (IPV) across a range of populations. This chapter summarizes theoretical models attempting to explain these associations, with an emphasis on social information processing models that describe how trauma impacts the ways in which we interpret and process our social worlds, core themes that may underlie trauma and abusive behavior, and emotion regulation difficulties. Possible mediators and moderators of this relationship are also discussed, including traumatic brain injury (TBI), neuropsychological deficits, substance use, depressive symptoms, and relationship conflict. Finally, we describe the literature on IPV interventions. While the literature is characterized by a lack of randomized controlled trials, small treatment effects, and flawed research designs, more promising trauma-informed intervention approaches are emerging that provide some reason for optimism.

Gilbar, O., Gnall, K. E., Cole, H. E., & Taft, C. T. (2020). Posttraumatic Stress Disorder, Intimate Partner Violence, and Trauma-Informed Intervention. In Violence and Mental Disorders(pp. 115-134). Springer, Cham. [retrieved 07/01/2020]: https://link.springer.com/chapter/10.1007/978-3-030-33188-7_7

Firebug! Dissociative Identity Disorder? Malingering? Or …? An Intensive Case Study of an Arsonist

Loewenstein, R. J.

Courts struggle with questions of how to assess competency to stand trial (CTS) and not guilty by reason of insanity (NGRI) in dissociative identity disorder (DID). Concerns about CTS include dissociative amnesia and unpredictable switching behaviors that could cause inconsistent information transfer across self states, with the defendant unable to access important legal information about his/her defense and to collaborate with his/her attorney. DID defendants could not conform their conduct to the law or know right from wrong due to dissociative amnesia, the seemingly independent actions of self states, and the disruption of reality testing by switching. The author presents the case of a woman charged with both a witnessed and an unwitnessed burglary and arson, the latter at the home of her former therapist. The author was the fourth forensic evaluator in the case. Disagreements included whether the defendant met diagnostic criteria for DID or was malingering, and whether she was CTS and/or NGRI. In clinical work with DID, "the whole human being" is held responsible for all behavior, despite reported amnesia or lack of subjective agency. The Discrete Behavioral States (DBS) model of DID avoids reification of the DID self states and their conflation as separate "people." This model supports evaluating the defendant at the level of specific self states, the self-state system, and that of the whole human being. The author concluded that the defendant met diagnostic criteria for DID and also was malingering its severity. She was competent to stand trial and legally sane.

Loewenstein, R. J. (2020). Firebug! Dissociative Identity Disorder? Malingering? Or…? An Intensive Case Study of an Arsonist. Psychological Injury and Law, 1-38. [retrieved 07/01/2020]: https://link.springer.com/article/10.1007/s12207-020-09377-8

No Association Between FKBP5 Gene Methylation and Acute and Long-Term Cortisol Output

Alexander, N., Kirschbaum, C., Stalder, T., Muehlhan, M., & Vogel, S.

Prior studies identified DNA methylation (DNAM) changes in a regulatory region within the FK506 binding protein 5 (FKBP5) gene as a crucial mediator of long-term negative health outcomes following early adversity. A critical mechanism underlying this link, in turn, has been suggested to be epigenetically induced dysregulation of the hypothalamic–pituitary–adrenal (HPA) axis. The purpose of this study was thus to investigate associations of FKBP5 DNAM with both acute and chronic cortisol output. Two hundred adults with differential exposure to childhood trauma (CT) underwent a laboratory stressor (Trier Social Stress Test) and provided salivary samples for the analysis of acute cortisol stress responses. In addition, hair cortisol concentrations were determined as a valid measure of integrated long-term cortisol levels. Whole blood samples were drawn for DNAManalyses of FKBP5 intron 7 via bisulfite pyrosequencing. In contrast to most prior work, only healthy participants were included in order to disentangle the effects of trauma exposure per se from those related to mental disorders. First, our findings did not reveal strong evidence for a robust effect of CT on FKBP5 intron 7 DNAM status, even if genetic predisposition (rs1360780 genotype) was taken into account. Second, FKBP5 DNAM levels were found to be unrelated to acute cortisol stress reactivity and long-term cortisol concentration in hair. The failure to demonstrate a significant association between CT and FKBP5 DNAM in an exclusively healthy sample could be interpreted as suggesting that individuals' mental health status may be a critical modulator of previously observed effects.

Alexander, N., Kirschbaum, C., Stalder, T., Muehlhan, M., & Vogel, S. (2020). No association between FKBP5 gene methylation and acute and long-term cortisol output. Translational Psychiatry, 10(1), 1-10. [retrieved 07/01/2020]: https://www.nature.com/articles/s41398-020-0846-2

DATES FOR YOUR DIARY IN 2020

2–7 August 2020.
International Childhood Trauma Conference. Australia.
https://professionals.childhood.org.au/conference/

August 8, 2020. Working with the Effects of Emotional Abuse, Severe Neglect & Invisibility. Online. Organized by Envision Counselling & Consulting.
https://www.eventbrite.ca/e/working-with-the-effects-of-emotional-abuse-severe-neglect-invisibility-tickets-112048991550?aff=erelexpmlt

11–13 September 2020.
International Attachment Conference. Ulm, Germany.
https://10times.com/international-attachment-conferenc

September 17-19, 2020. A Three Day EMDR Advanced Webinar on Dissociation. Organized by Gray Matters Therapy Workshops, LLC. Online.
https://www.intra-tp.com/wp-content/uploads/2020/05/GMTW-Fall-2020-Webinar-Flyer-Blue.pdf

25–27 September 2020.
Congress Attachment and Trauma: Effective Clinical Interventions and Research. Philadelphia, Pennsylvania.
https://uk.international-isc.com/negozio/workshop/philadelphia-effective-clinical-intervention-and-research-attachment-and-trauma/

September 26-27 & October 3-4, 2020. EMDRIA Annual Conference. Online.
https://www.emdria.org/emdr-training-education/emdria-conference/

October 9-10, 2020. Workshop "EMDR bei Persönlichkeitsstörungen". Vienna, Austria. http://www.emdr-institut.at/spezialseminare/data7012.php

October 12-13, 2020. EMDR en Dissociatieve Stoornissen, deel 2. Integrativa. Belgium. http://www.integrativa.be/spip.php?article181&lang=nl

October 15-16, 2020. Traiter les troubles dissociatifs avec l'EMDR : l'approche progressive. Niveau 1. Luxembourg. Résilience Institut Luxembourg. http://www.resilience-institut.lu/agenda/2020/emdrdissociation1

On line Hybrid Course: Dissociation in Children and Adolescents: Assessment and Treatment -https://bictd.org/dissociation-in-children.html

PLEASE LET US KNOW ABOUT FUTURE EVENTS IN YOUR COUNTRY!

Send the dates, title, location, speaker(s), language, website and contact information to Dolores Mosquera, doloresmosquera@gmail.com

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