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ESTD NEWSLETTER

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Volume 10 Number 3, December 2020

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QUARTERLY QUOTE

Rick Kluft

"I try very hard to make difficult and painful aspects of psychotherapy more tolerable and less overwhelming. My style is "the slower you go, the faster you get there." A gentler pace creates fewer difficult moments, and that often translates into less turmoil and more rapid results"

Anca Vilma Sabau
ESTD President

LETTER FROM THE PRESIDENT

I hope this letter finds you well.

Autumn brought almost every European country the second wave of the Pandemic. We are living through this special time and hope to thrive. Meanwhile I am writing, as President, my last column for the newsletter and I want to thank you all for your support during the past years.

Time is running fast and we spent two challenging years together with good but also with difficult moments. 2019 was the year that marked the ESTD Conference from Rome. We all have nice memories from that time, interesting and high quality presentations and encounters with old and new friends and colleagues. Our community grows with almost 100 new members, reaching around 600 active members, with a very strong national Italian and British group and a fast growing Polish ESTD community, which is encouraging and makes our efforts more purposeful. We are in a stable financial position and in very good collaboration with our colleagues from ISSTD and EMDR Europe, which is a normal and fruitful process as many of us are also members of these organizations. Finally, after many years of hard work from Raphael Gazon and our new assistant Barbara, the website is fully functional and flexible. We encourage you to take a visit at www.estd.org where you will find new educational videos, articles, interviews, Guidelines and direct access to EJTD (European Journal for Trauma and Dissociation). The safety of our members is a priority for the Board so we are taking steps to produce guidance about internet security aspects. Different aspects in relation to this issue are going addressed monthly and updated by our assistant. From this year the mentors program is functional so those who need more information in this regard can email our Board colleague Paola Boldrini.

The new realities moved our work toward an online space so future plans include organization of workshops and small conferences. We took the first step this year in September in Poland where our colleagues Igor Pietkiewicz and Radek Tomalsky hosted the first online Regional ESTD Conference very successfully.
We thank our colleague, Prof Andrew Moskowitz, for his outstanding efforts in the field of trauma and dissociation and for the wise guidance he offered us during this long period on the Board. In January 2021, he will leave the Board and step into the circle of Past Presidents and we will certainly miss his input in our Board meetings.

Towards the end of this year our colleague Raphael Gazon, a very skilled trainer and clinician from Belgium, will be the ESTD President and our colleague Igor Pietkiewicz will take the position of President Elect, specifically being in charge of the membership committee. The Board is functioning as a compact being so things will continue and develop physiologically.

I express my deepest respect for all of the members of this Society and I wish you all to be well in all aspects!

Kind regards,

Anca Vilma Sabau, MD
President, ESTD

NEWS

Hot News Items from Valerie Sinason

Dr Sarah Nelson has just been awarded the OBE in the Queen's birthday honours for her longstanding work on behalf of urvivorsof childhood sexual abuse.

Background:

She has researched and campaigned on child sexual abuse for many decades, and have been professional adviser to both the Scottish Government and the Scottish Parliament.

After moving from professional journalism to a university career her qualitative research projects with the Centre for Research on Families and Relationships (CRFR) of Edinburgh University have included the mental health needs of female survivors, and life history research with male survivors. She has worked closely with abuse survivor themselves and their third sector support agencies, and tried to reflect their own voices, producing accessible lets and many presentations for policymakers, practitioners and survivor activists. Issues have included criticism of current child protection systems, physical health legacies of abuse, the voices of young survivors and models of community prevention. Her academic research is reflected in research papers, book chapters and in books, which span 30 years from theinfluential feminist work Incest: Fact and Myth (Stramullion, 1987) to Tackling Child Sexual Abuse: Radical Approaches to Prevention, Protection and Support (Policy Press, 2016).

She came from Inverurie in Aberdeenshire and now live inNewport on Tay in Fife.

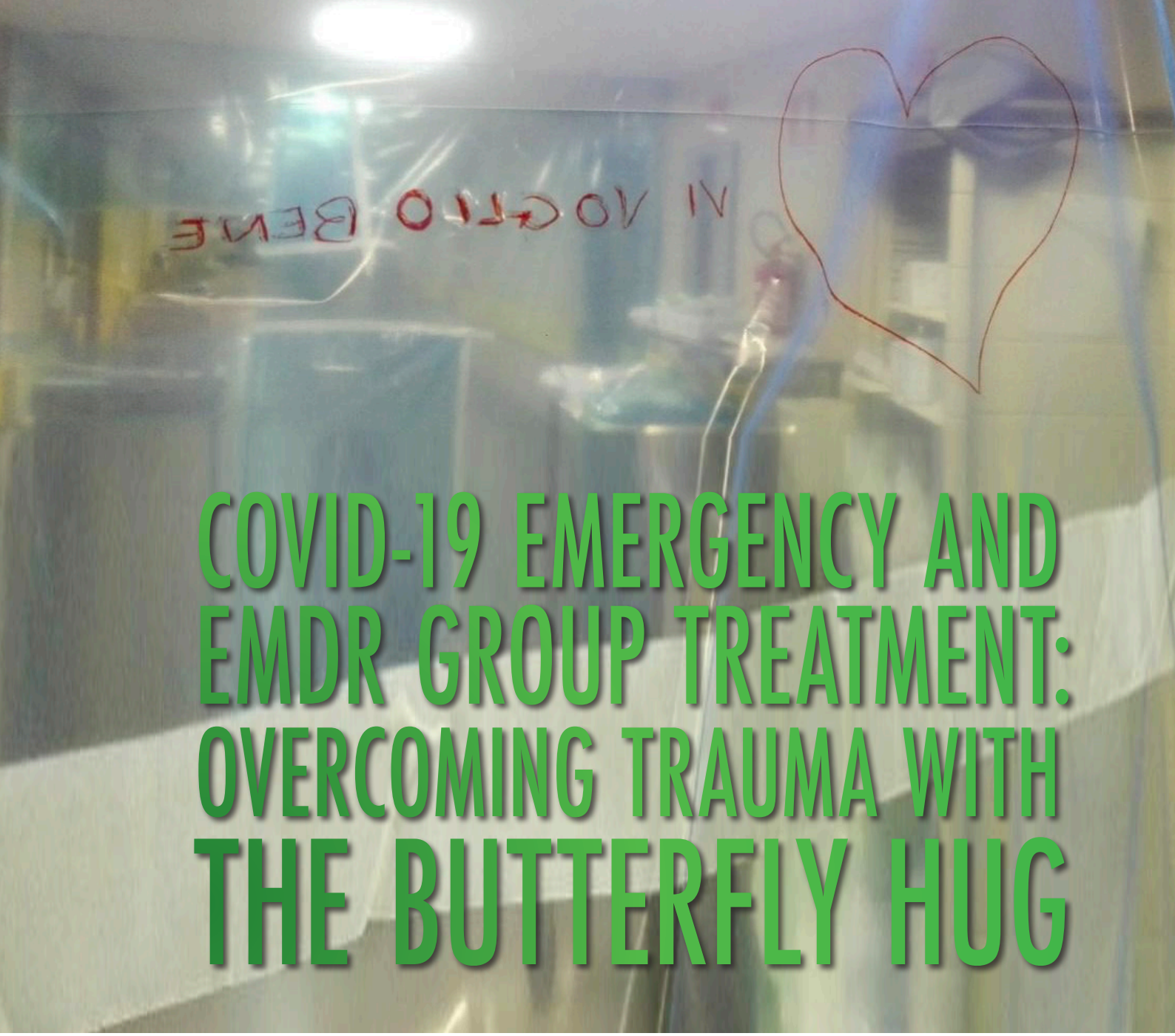
New Covid Guidebooks

Dr Gilbert Kliman,MD, a 90 year old psychoanalyst and psychiatrist is Medical Director of the Children's Psychological Health Center in San Francisco.

As well as his ground-breaking work with traumatised and deprived children in the USA he has also created free guided activity workbooks on covid for children all over Europe. Together with his wife Dr Harriet Wolfe, who is also a child and adult psychoanalyst, he has created a new workbook "My Pandemic Story". These are available in German, Italian, Dutch, French, Portuguese, Croatian, Russian and Turkish. On his website you can access a form asking for a license to download these workbooks. London child psychoanalyst Jenny Davids, as Director of Africa Projects, will take the project to rural areas in Africa.

The whole aim is to find a common language to educate deprived children and their families psychologically.

URL: childrenspsychologicalhealthcenter.org



COVID-19 EMERGENCY AND EMDR GROUP TREATMENT: OVERCOMING TRAUMA WITH THE BUTTERFLY HUG

By: Roberta Invernizzi, Giada Maslovaric, Vittorio Rigamonti, Elisa Fogliato

COVID-19 emergency: an unprecedented pandemic

"I didn't eat for days. I was very scared. I was counting the sirens of ambulances even when I was at home, and I kept picturing the image of a wounded hospital as if it actually had a wound that cut it in half and that was bleeding." (nurse in critical care unit, Phase 2)

"It's all surreal. Some patients were stroking the screen of the iPad while talking to their loved ones, and then there were those dying of air hunger..." (nurse in critical care unit, Phase 1)

"When I first heard about China, everything seemed far away. People at the airport were finding it funny to see Chinese people walking around in masks. Then, from one day to the other, it became a nightmare... The still image is that of a blender that works at different speeds, depending on whether you're in or out of hospital wards completely transformed by the

emergency, in a dirty or clean area." (doctor in critical care unit, Phase 2)

On 31st December 2020, WHO headquarters in China were notified of cases of pneumonia of unknown origin in the city of Wuhan, in the Chinese province of Hubei. This started to outline the scenario of a health emergency that would affect the community very quickly, with increasingly global borders and with an incredible upheaval in the sense of safety and control.

The pandemic in Italy: beyond vicarious traumatisation

Understanding the mental health consequences of an unprecedented pandemic was, from the start, an important concern for those who were structuring support interventions for healthcare personnel (De Mei et al., 2020; EMDR Italy). As psychologists who worked (and continue to work) in health care during the COVID-19 epidemic, we experienced the urgency of providing the most effective and evidence-based responses possible, aware that the health emergency we were experiencing (and that the world is still experiencing) represented (and represents) a challenge to psychological resilience for all.

Many documents and reports have given indications (ad interim) for the management of work-related stress during this emergency (CSTS, 2020; WHO, 2020a; ISS COVID-19, 22/2020), highlighting very well how the psychosocial risk factors, closely linked to work organisation and employees' safety and health, have been greatly amplified by this emergency, starting from those related to personnel's safety, like prevention and protection measures. Besides physical stress, healthcare workers have also been exposed to a high level of psychological stress: fear of being infected and of spreading the infection, high mortality, suffering for patients' and colleagues' death, changes in work practices and procedures, the need to provide emotional support to patients in isolation and, in many cases, to accompany the dying ones. And then social isolation, due to distancing measures (including within their families) and quarantine or, in some cases, discrimination and stigma (WHO, 2020b).

Radical changes in routine, lockdown measures, daily bulletins of infected and deceased people, testimonies of healthcare staff or of people who survived the illness and the death of their loved ones in total isolation from their families, as well as the separation of healthcare workers from their children, are just some of the many significant aspects that affected many people's lives in the first half of 2020. What we have experienced in this pandemic is that healthcare professionals were, in spite of themselves, directly exposed to the trauma of contracting the infection and also living, through indirect exposure, the trauma of the COVID-19 patients that they were treating in hospitals. If we take as a reference the classification proposed by Taylor and Frazer (1981) – which divides the victims of Critical Accidents (Mitchell, 1983) into 6 levels – rescuers are classified as 3rd level victims (or 3rd type victims). This category has been extended to include not only those who operate in situations of natural and/or artificial disasters, but also those who operate in emergencies (Iacolino and Cervellione, 2019) such as doctors, nurses, social and welfare workers, psychologists, law enforcement agencies and all those who operate in complex scenarios. Moreover, what we have learned from experience during the COVID-19 pandemic is that these healthcare workers are 3rd type victims but could be also victims at all the other levels. And some of them were.

They could be 1st type victims (those who directly suffer the traumatic/emergency event) because they died from COVID-19 as a result of contagion; 2nd type victims (relatives or loved ones of the deceased and survivors) because of the possibility of losing a family member from COVID-19; 5th type victims (those who, due to their pre-critical characteristics, may react to the event by developing a short or long term psychopathological disorder) due to the presence of fragility or previous traumas with respect to which the traumatic impact of the pandemic leads to the development of post-traumatic or other symptoms. In addition, all the healthcare professionals that

worked in the COVID-19 emergency were victims of 4th type (the community involved in the disaster) as they belonged to the population affected by the pandemic. They were all also victims of 6th type (those who could have been victims of 1st type) because of the continuous risk of contracting the virus that could, in fact, lead to death from COVID-19. This happened to many healthcare workers. In our country and in the world.

"When I was moved to a COVID ward, it was endlessly sad. I hardly remember anything about that period. Once I locked myself in a closet because I couldn't stand CPAP anymore. I also had to put it on a colleague ... Every morning I counted who was there and who was no longer there because they died during the night. The first thing I wanted to know was whether all the nurses were present or missing because they had also fallen ill..." (nurse coordinator in critical care unit, Phase 2)

"The image that keeps coming to the mind is that of the rows of bodies in the morgue. I have wondered about the dignity of dying and about accompanying the dying in this pandemic. Those days I thought it was the end of the world. An immense pain. I never cry, but now I keep crying." (department nurse coordinator, Phase 3)

"That night I saw ten people die, one after the other. I shared everything with a colleague and from that moment on I was no longer afraid of being infected. Only to infect my children. So I called my ex-husband and told him to take our children with him. The worst moment was when I left them, because I felt guilty." (doctor in critical care unit, Phase 2)

We wondered, in the light of these reflections, if this pandemic has not in fact subverted our references in emergency, forcing us to consider more co-existing possibilities and interpretations, such as that of vicarious or secondary traumatisation together with that of primary traumatisation. Vicarious trauma and direct trauma. As well as that of being victims on multiple levels.

For this reason, in order to provide adequate psychological support, we had to use different and complementary approaches, quickly evaluating their effectiveness so we could be ready for new redefinitions and adjustments, also resorting to our creativity. In fact, the complexity of what we were dealing with as the pandemic was spreading led us to re-write our knowledge on psychology in emergency so we could be of real support to first responders (including ourselves), patients, and their families (even if remotely).

The experience in emergency that we are going to describe is the result of the reflections that we have shared - of the intelligent, human and creative professionalism that we have rediscovered while being at the service of others (and of ourselves, as a group of psychologists); of an openness to our country and the world favoured and supported by the (many) people of EMDR Italy Association, who have accompanied us and worked with us remotely while we were inside those hospitals this pandemic "wounded". It is also the result of all the pain we have gone through and the experiences of death we have experienced. It is the result of life and hope that we have shared and that have helped us to always look ahead.

In Italy, and especially in Lombardy where there has been the highest number of positive cases and deaths, the very rapid evolution of the pandemic has forced hospitals to adapt continuously.
All this has also happened in our hospital units (ASST in Lecco), which have been completely reorganised, from one day to the next, to deal with the SARS-CoV-2 emergency.

The Crisis Unit, which operated at different levels, was trained by 14 EMDR psychologist psychotherapists and 6 psychotherapists with other kinds of training backgrounds, for a total of 20 psychologists. Specifically, the psychological support interventions with EMDR group treatment for critical care unit staff will be described as follows.

Psychological support interventions with EMDR group treatment for critical care unit staff

"It was an unexpected event, a crescendo. My feet were swollen in the evenings. Then my colleague got sick and I was afraid: I was calling him and I could hear him panting. Today I know that I can protect myself, that I am more protected in the hospital than outside, that I can take care of myself and reclaim my time…" (doctor in critical care unit, Phase 2)

"It all started with the colours and the blossoming of a wonderful spring. In the background, the image of war, but we were not at war. We were "at care": caring for each other, our colleagues, our families and our children, isolating from them to protect them. We were also taking care of ourselves in order to be able to support others. Protecting ourselves and protecting them." (psychologist in critical care unit, Phase 1)

The healthcare workers we met during our support interventions were in a complex situation, characterised by the immediate and repeated change in their activities and procedures, teams, and work spaces/places, in a totally new and unpredictable scenario (ISS COVID-19 Report, 22/2020).

It is precisely in this context that the Crisis Unit activated brief EMDR group interventions for critical care unit staff, adapting to the organisational realities and needs – only partially expressed – of each ward, within a real "emergency vortex". The continuous and untiring work of outreaching was necessary to reach all the staff and support them in their task of facing the emergency, "protecting those who protect." As matter of fact, this evolving dimension of the pandemic has initially hindered the request for help, for various reasons. And yet, surprisingly and unexpectedly, we experienced the fact that it was sufficient to work with a single group (which for security reasons could not exceed the number of 3 participants) to generate an intrinsic and supportive force that pushed from within the staff of an entire ward to allow themselves to be helped and supported. In this regard, many reported the feeling that their colleagues were like their "second family" in the context of this emergency.

Three meetings were proposed to the staff, following a protocol – which we will call **brief EMDR group treatment** – created by the re-elaborated version of the guidelines for the stabilisation-decompression of Critical Incident Stress Management (CISM, Mitchell and Everly, 2001; Quinn, 2009) and by the specific EMDR protocols for Acute and Recent Traumatic Events (Shapiro and Laub, 2008; 2009).

The objectives of the intervention were a) to normalise emotional reactions, b) to break the sense of isolation, c) to screen for symptoms in the acute peritraumatic phase and to prevent the onset of disorders related to the acute stress reaction and post-traumatic disorder and d) to elicit individual and group resilience and post-traumatic growth.

The following tools were used in order to evaluate the effectiveness and the outcome of the interventions a) in the pre- (first EMDR group session) and post-intervention phase (third EMDR group session), the specific Impact of Event Scale IES-R (Pietrantonio et al., 2003) and b) at the end of the intervention, the PTGI Posttraumatic Growth Inventory (Gabrieli and Pietrantoni, 2006).

As this was an emergency with specific phases, the protocols used in Phase 1 (March – May 2020) have been re-adapted for the Phase 2 (end of May – mid-June) and Phase 3 (mid-June onwards). In these last two phases, the brief EMDR group protocol was used in the first group meeting, while the EMDR group protocol with the four quadrants was used in the following two meetings. In all phases, the third EMDR group meeting analysed, in depth, the topic of post-traumatic growth, with the composition of sentences that were then posted on the walls of the various wards of our hospitals.

In all phases – especially in Phase 1 – the exercises related to the stabilisation phase were adapted to this specific emergency, where "breathing" represented a trigger for the majority of the staff, making the breathing exercises in the stabilisation phase difficult. For this reason, we preferred to use the Grounding exercise where the breath is associated with a well-defined body image of stability.

The psychological early interventions carried out in our "wounded" hospitals during this emergency demonstrated what it meant to work in health care during the COVID-19 pandemic. In this perspective, the Crisis Unit experimented, in humanitarian cooperation with EMDR Italy Association (and with many colleagues in Italy and around the world), a clinical solidarity capable of generating effective actions and strategies in response to an unprecedented collective trauma. Together we were able, despite everything, to face and treat (as we could) this trauma, and we discovered to be more resilient and open to the future. Whatever it may be. As we have learned to do during this pandemic without ever deserting the impact with reality.

Without forgetting. With a perceptive and resilient look to the future.

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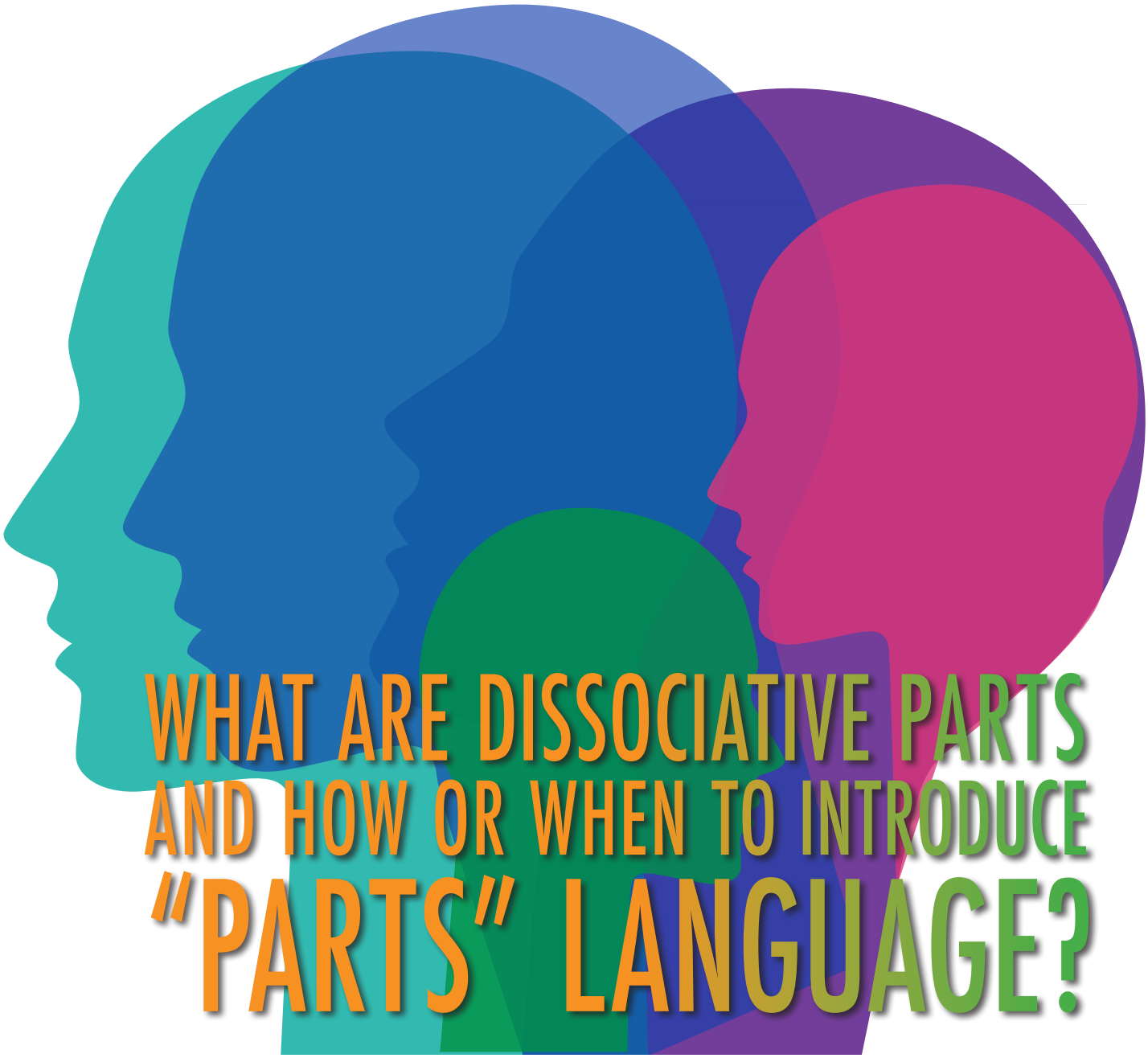

WHAT ARE DISSOCIATIVE PARTS AND HOW OR WHEN TO INTRODUCE "PARTS" LANGUAGE?

By: Dolores Mosquera

Clinicians who work with complex trauma cases often find themselves challenged by issues related to dissociative parts and the appropriate use of "parts" language during treatment. Today, we wish to reflect on the following four questions, which are frequently brought up by clinicians during training and consultation.

1. What are dissociative parts?
2. How to distinguish dissociative parts from ego states?
3. When and when not to use "parts" language?
4. How to work with or talk about "parts" when patients do not feel comfortable recognizing that they have parts?

What are dissociative parts?

Dissociative parts often have a distinct first-person perspective - that is, a sense of "I, me and mine" - (Nijenhuis & Van der Hart, 2011; Van der Hart et al., 2006) as well as a sense of identity, self-representation, autobiographical memory, and personal experience (Kluft, 1988, 2006; Steele, Boon, & Van der Hart, 2017). The client's lack of a unified sense of identity could be expressed through sentences such as, *"It was her, I would never do/say such things;" "Sometimes I feel as if I'm going crazy, I don't have control over my actions, my hands take control and I can only watch in the background;" "There is a monster inside of me, it doesn't let me eat or sleep;" "I didn't try to kill myself, he* (referring to another dissociative part) *tried to kill us,"* and is often referred to as lack of personification (Van der Hart et al., 2006). Notice how clients tend to talk about parts as if they were different people, frequently using a third-person perspective to describe their inner experiences or what they see, notice or hear from their dissociative parts.

The notion of dissociative parts having their own partial autobiography and sense of identity makes a lot of sense in most cases, but it might not apply to all parts completely. First, there are emotional parts (EPs) stuck in trauma time that do not seem to have autobiographical memory or might not be able to recognize it as such because it is felt as current experience, as if it were occurring now. And second, these parts might not be experienced or described by clients as having a distinct first-person perspective - even though they do have their own perspective, limited as it may be to the time of trauma. But they can still be experienced as foreign, in the sense of the client not feeling control or being able to do anything about them. Therefore, it can be challenging to work with these parts, especially when it comes to time orientation or becoming aware of present reality.

How to distinguish dissociative parts from ego states?

Ego states have been described as having permeable boundaries, no significant amnesia, no significant separate autobiography and a sense of belonging to the person as a whole (Kluft, 1988, 2006; Steele et al., 2017). Ego states consist of mental representations that might involve some type of conflict or integrative deficits (Mosquera & Steele, 2017), but are not invested in being separate and are not experienced as such. Hence, their perspective is not significantly different from the person as a whole. These are normal phenomena that we all experience and do not indicate the presence of a dissociative disorder.

In general, ego states differ from dissociative parts in their lack of autonomy and elaboration, personal experience and memory, and unique self-representation and first-person perspective. Clients usually acknowledge ego states as part of the self, which is mostly not the case for dissociative parts, unless the client has been through significant therapy work.

In Complex PTSD and some OSDD cases, ego states may present as having less permeable boundaries, some amnesia for the past but not the present and a greater sense of literal "not me" (Steele et al., 2017). These experiences could be understood as belonging to dissociative parts, but this does not mean that they will require the work often needed with more clearly divided parts. It might be useful to think of them as more elaborate ego states or as being on the border between ego states and dissociative parts. Common statements are, *"I know these parts are me, but they don't feel like me," "I know these are my voices, I know that I am producing them, but they don't feel like mine,"* or *"When I react like that it feels as if I was acting like someone else/like my mother."* Notice how these statements reflect a first-person perspective and greater conflict around some of the emotions that may be more difficult for the client to regulate, tolerate or accept. In these cases, it can be more challenging to distinguish ego states from dissociative parts. However, if we listen carefully, we will not pick up on the phobic avoidance that is often present in more elaborate dissociative parts that have increased autonomy. In these cases, many clients experience these parts as "Not Me" and usually want "to get rid of her/him/it." Some

dissociative clients can be phobic of certain parts and not of others, while still experiencing conflict around how to relate with them or how these parts relate to other parts that are more challenging.

The language that is used by the client can offer clues that can help us differentiate between dissociative parts and ego states. With ego states, the language is often more metaphoric, especially when talking about child parts. These are often described as *"the little me," "me when I was little,"* or *"the hurt part of me that I still notice,"* among others. These descriptions are usually stated in first-person perspective, as belonging to oneself, with no relevant conflict. Some clients may experience conflict around their "younger selves," often related to adverse experiences, traumatizing events or the meaning of that label attached to their inner experience. For some clients, using language that refers to *"the younger me," "my little me," "my little girl,"* or *"the girl I was"* simply adds a distancing quality that greatly differs from the conflict in dissociative parts. When dissociative parts are present, the use of this language is not just a metaphor of their experience, but a perception of something that does not belong to the client, such as the part functioning in daily life. In addition, there is a large amount of energy often spent in maintaining the separation between the different parts.

When and when not to use "parts" language?

The language that our clients use spontaneously can help us decide whether it might be a good idea for us to use "parts" language. It is important to keep in mind that, for many clients, "parts" language is a way to introduce some distance when describing behaviors, thoughts or feelings that they do not particularly like or fully understand. This is so both in these simpler cases as well as in those that are more complex, in which these thoughts, behaviors, or feelings are felt as strange, odd, foreign and not belonging to me.

As a rule of thumb, if possible, it is always a good idea to use the client's language from the beginning (Mosquera, 2019). On the one hand, when clients talk openly about their parts it normally is a good idea to follow up on their wording. On the other hand, when a client does not feel comfortable with the use of "parts" language, it is preferable not to use it. Some clients get defensive when they hear the word "part" and in those instances, there is no need to insist; it will be pointless and lead to more resistance or defensiveness. When a client becomes defensive or notices resistance, it is important to validate their experience and respond with curiosity and care, as such resistance and the reasons for it need to be explored in a way that the client can tolerate.

However, there are some exceptions to the rule of using the language preferred by the client. One will be when we observe that clients are using "parts" language as a way to avoid taking responsibility for their actions, using expressions such as, *"I am not responsible for that behavior because this other part did it"* or *"It was the other me who said it; my friend shouldn't be angry at me."* In addition, some clients may talk about "inner people" or prefer to talk about their parts in a way that gives them too much autonomy. In these circumstances, we can agree to use both ways of referring to parts: the client can continue talking about "inner people," and we may respectfully acknowledge that and also maintain our "parts" language: *"What you call your inner people and I call your parts…"* or *"Those parts of you that you experience as inner people."*

Overall, "parts" language can be used with the different presentations when it helps with the work we are doing, and it should be avoided when it gets in the way of therapy or improvement in clients.

How to work with or talk about parts when patients do not feel comfortable recognizing that they have parts?

When clients do not feel comfortable with having parts or have difficulties recognizing their existence, a good way to approach this issue is to explore whether they notice conflict inside or things that are difficult to explain to others and then ask them to please help us understand their inner experience. Some clients will refer to the different parts of the self/personality by using expressions such

as "different me's," "voices," "thoughts," "opinions," "conflicts in me," "pieces," or "fragments," which really offers information for the therapist about how clients experience their parts. It is important to keep in mind that some of the terms used may have an excessively high degree of reality (e.g., "inner people" or "personalities") unduly emphasizing their separateness, and others may have an extremely low degree of reality (e.g., "aspect") ignoring the fact that parts having their own first-person perspective (Moskowitz & Van der Hart, 2019).

Using other metaphors can be as effective, especially if clients feel comfortable with them. Richard Chefetz (2015) uses the expression "different ways of being you," which is a creative and integrative way of using an easier language for some clients. And again, even a generally good integrative way of using language can evoke resistance in some clients. For instance, those having perpetrator-imitating parts could, early in therapy, protest against having them labeled as "a way of being you." Or parts that are emotionally involved in maintaining their own sense of separateness could even feel narcissistically hurt, being reduced to merely "a way of being."

Summarizing, even though sometimes you may need to adapt to using a language that may not feel natural for you, what really matters in therapy is being able to communicate and explore in ways that feel comfortable for the client. Be creative when approaching this issue, since it is always possible to find personalized ways to explore and talk about the patient's inner experience that do not involve mentioning the word "parts."

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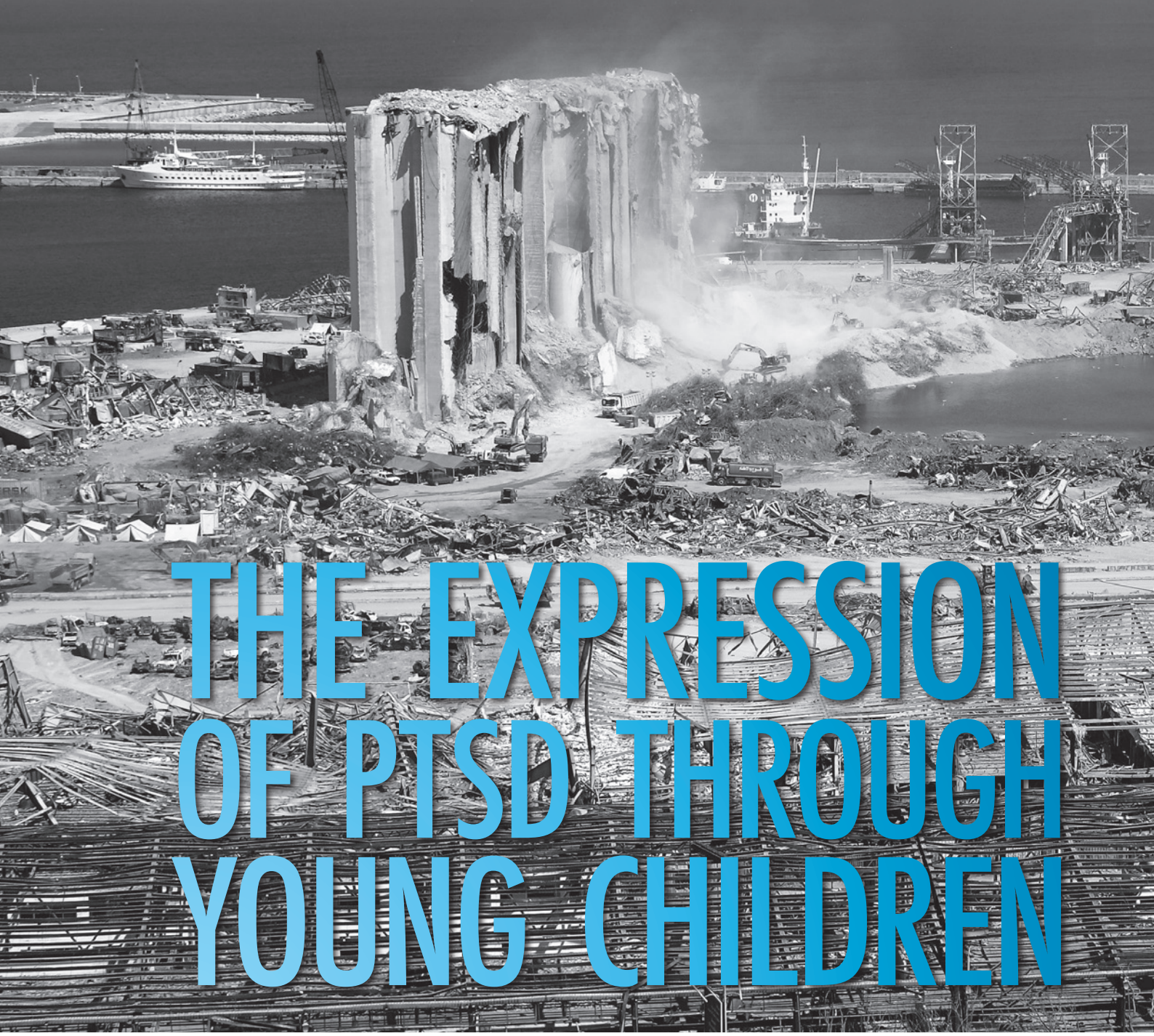

THE EXPRESSION OF PTSD THROUGH YOUNG CHILDREN

By:Daniele Pichon and Dana El Khatib

August 4th, 18:10hrs... A devastating ammonium nitrate explosion - Beirut is shred to bits! Blood-drenched, dumbstruck inhabitants roam the streets in a state of shock, children are mute, incapable of any form of expression. Desperate, they cling onto a soothing parent who attempts to explain what just happened, but even they are incapable of finding a rational explanation to the catastrophic incident. How can they assume their role as their child's focal point for comfort and reassurance… "Mummy, Daddy, my indestructible, unfailing, UNTOUCHABLE heroes!"

Days go by, the clinic is repaired, we are overwhelmed with appointments. Young children, and not so young children, come in and attempt to express their deeply-anchored, suppressed turmoil… fear on their faces… fear at the slightest sound within their surroundings, their gaze scrutinizes every inch of the room, and finally the words come out… "Was everything broken here too?"

We tried our best to camouflage the destruction, but the children are still searching for answers…. "Everything is broken… EVERYWHERE!" They are insecure; terror is devouring them from deep down..

PTSD… that's what it is. How can we ask children to express themselves after having seen their blood-drenched mother, father and siblings right before their eyes? They were certainly taken into either their parents or strangers comforting arms, running for help, crossing mountains of debris, in streets crowded with screaming bloodied casualties desperately calling for help and for their loved ones. Some children never found their parents; they were the victims of a state's fatal negligence.

The little ones are sitting right next to me…always the same words. "Will there be any more big bangs?"

How can a therapist reply? How can they reassure the child? Make them speak?

Younger children, 3 and 4 years old, refuse to talk or draw. This is where we try to introduce figurines and a playhouse but they are reluctant.

"NO! You don't understand! It's gone! The house is broken… ALL BROKEN!"

This is when the session comes to an end. They want to leave. Escape, denial, defense and pushback mechanisms take the lead along with sleeping disorders that may be accompanied by a kind of "apathy" or "agitation" in certain cases.

It is easier for older children to express themselves. It is often more formulated, although sometimes, we can also observe the denial mechanisms coming into action.
"Yes. I was really scared. I cried a little bit, not a lot. But now I've forgotten everything."
Yet their drawings say otherwise. There are drawings of the explosion, the destruction, and bodies of victims covering the ground.

My career began during the Lebanese Civil War when I worked as a part-time clinical psychologist in a school, and my afternoons were spent in a private clinic.

Early on in the private clinic, I encountered very difficult cases that were practically impossible to diagnose. Every time I saw a child, a new "label" came to my mind and it didn't make sense as at the end of the session, the child's behavior would change a great deal following an adapted psychological support.

I have worked with many children with "learning difficulties," making the difference between a cumbersome unadapted pedagogy paired with an unadapted academic pace as opposed to a child's pace, often burdened by an "overload" of schoolwork. This academic pace has had a great number of consequences such as frequently mixing up pathologies, such as ADHD, ADD, Dyslexia, Dysorthography etc. Children ended up being excluded from the academic system, since there was no support system in place at this time.

In 1987, I opened a specialized center for autistic children. CDDP (Centre de Diagnostic et de développement pour la Personne) Working and

offering therapy to these children is a passion. I worked exclusively with a team of clinical psychologists, and together we established specialized programs inspired by American programs (TEACCH, LOVAAS, ABA), keeping a ratio of "one to one" or "one to two".

Today, we work following the same structure. In the morning we welcome our autistic children and in the afternoon we have clinical consultations, which include a wide range of children's "difficulties" that are specific to the culture and context in which they live and with adults.

In their little heads, they are unwell, very unwell. The victims, who sought refuge in their country homes, develop the "urban phobia". The terror that ravaged them is crystallized in the city. There is a flat refusal coupled with anger and panic attacks to

get in the car and return to their house in the city of Beirut.

The fear of death has become a certainty. Death hides in every corner.

"I am alone! My indestructible, unfailing, UNTOUCHABLE heroes were affected, wounded, handicapped or destroyed. How can they protect me if it happens again?"

Healing all this takes time. Therapy and/or parental support are key to overcoming this tragedy and helping the little ones rebuild their safe haven.

We use several therapeutic approaches to help the little ones overcome their trauma:

- Asking them to explain and to say where they were that day before and after the explosion.
- Asking them what they felt.
- Asking them to express the event through play or drawings.
- Creating a secure framework (with the child's help) where they will be able to grow and thrive.
- Attempting to let them formulate the exact role of each parent that day.

For the little ones who lost a parent on that tragic day, work will need to be done on the mourning process.

Danielle Pichon is a Lebanese Clinical Psychologist and Neuropsychologist, living in Beirut. Her work involves the application of a cognitive, individual and adapted program for children with autism to help them develop the "self". This process helps to develop the autonomy and expression of the autistic child's emotions, while supporting them to structure their references in order to fight their internal fears.

Dana El Khatib, is a Clinical Psychologist and assistant to Mrs. Danielle Pichon.

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!

Dissociative Identity Disorder: Out of the Shadows at Last?

Reinders, A. A., & Veltman, D. J.

Dissociative identity disorder (DID) is a severely debilitating disorder. Despite recognition in the current and past versions of the DSM, DID remains a controversial psychiatric disorder, which hampers its diagnosis and treatment. Neurobiological evidence regarding the aetiology of DID supports clinical observations that it is a severe form of post-traumatic stress disorder.

Reinders, A. A., & Veltman, D. J. (2020). Dissociative identity disorder: out of the shadows at last?. The British Journal of Psychiatry, 1-2.
[retrieved 11/10/2020]: https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/dissociative-identity-disorder-out-of-the-shadows-at-last/8E2884FA8669A9A64790E5C47AD72DC7

Delusional Beliefs and Their Characteristics: A comparative study between dissociative identity disorder and schizophrenia spectrum disorders

Martinez, A. P., Dorahy, M. J., Nesbit, A., Palmer, R., & Middleton, W.

Firmly held beliefs that have a delusional quality are commonly experienced in those with schizophrenia spectrum disorders (SSD) and have been reported in those with dissociative identity disorder (DID). However, no study to date has compared delusional belief content and characteristics between these diagnostic groups. This study examined delusional content, and the degree of conviction, preoccupation and distress associated with them in 50 participants with DID and 50 with an SSD exploring also dissociation and childhood trauma as predictors of delusional beliefs. Multivariate analysis of variance and linear regressions were conducted to explore differences between beliefs and characteristics and to examine their association with dissociation and childhood trauma. The SSD sample presented more self-referential delusional beliefs and characteristics compared to the DID group. Yet, the DID group had more mistrust delusional beliefs and characteristics in comparison to SSD participants. Mistrust beliefs were predicted by depersonalization/derealization in the DID sample, but did not predict any delusional belief in the SSD sample. The content of fixed beliefs differs between DID and SSD samples and in this study depersonalization/derealization experiences were related to mistrust beliefs but not to other delusional forms, and only in the DID sample.

Martinez, A. P., Dorahy, M. J., Nesbit, A., Palmer, R., & Middleton, W. (2020). Delusional beliefs and their characteristics: A comparative study between dissociative identity disorder and schizophrenia spectrum disorders. Journal of Psychiatric Research, 131, 263-268. [retrieved 11/10/2020]: https://www.sciencedirect.com/science/article/abs/pii/S0022395620309730

Shards of Glass and Dark Rituals (English transcript)

Terlingen, S., Jaspers, H. & Blok, S.

Over the last year, Argos collected the experiences and stories of over two hundred victims of organized sexual abuse. A hundred and forty victims told us about ritual abuse. In the radio documentary below, Argos highlights their stories and discovers unsettling similarities.
This documentary aired on Dutch national radio (NPO Radio 1) on June 27, 2020. Original title: Glasscherven en duistere rituelen.

Terlingen, S., Jaspers, H. & Blok, S. (2020, 27. Juni). Shards of glass and dark rituals (English transcript). argos. [retrieved 11/10/2020]: https://www.vpro.nl/argos/lees/nieuws/2020/glass-shards-and-dark-rituals-english-transcript-.html

Large-Scale Functional Brain Network Architecture Changes Associated With Trauma-Related Dissociation

Lebois, L. A., Li, M., Baker, J. T., Wolff, J. D., Wang, D., Lambros, A. M., ... & Gruber, S. A.

Objective:
Dissociative experiences commonly occur in response to trauma, and while their presence strongly affects treatment approaches in posttraumatic spectrum disorders, their etiology remains poorly understood and their phenomenology incompletely characterized. Methods to reliably assess the severity of dissociation symptoms, without relying solely on self-report, would have tremendous clinical utility. Brain-based measures have the potential to augment symptom reports, although it remains unclear whether brain-based measures of dissociation are sufficiently sensitive and robust to enable individual-level estimation of dissociation severity based on brain function. The authors sought to test the robustness and sensitivity of a brain-based measure of dissociation severity.

Methods: An intrinsic network connectivity analysis was applied to functional MRI scans obtained from 65 women with histories of childhood abuse and current posttraumatic stress disorder (PTSD). The authors tested for continuous measures of trauma-related dissociation using the Multidimensional Inventory of Dissociation. Connectivity estimates were derived with a novel machine learning technique using individually defined homologous functional regions for each participant.

Results: The models achieved moderate ability to estimate dissociation, after controlling for childhood trauma and PTSD severity. Connections that contributed the most to the estimation mainly involved the default mode and frontoparietal control networks. By contrast, all models performed at chance levels when using a conventional group-based network parcellation.

Conclusions: Trauma-related dissociative symptoms, distinct from PTSD and childhood trauma, can be estimated on the basis of network connectivity. Furthermore, between-network brain connectivity may provide an unbiased estimate of symptom severity, paving the way for more objective, clinically useful biomarkers of dissociation and advancing our understanding of its neural mechanisms.

Lebois, L. A., Li, M., Baker, J. T., Wolff, J. D., Wang, D., Lambros, A. M., ... & Gruber, S. A. (2020). Large-Scale Functional Brain Network Architecture Changes Associated With Trauma-Related Dissociation. American Journal of Psychiatry, appi-ajp. [retrieved 11/10/2020]: https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2020.19060647?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed

Persistent Genital Arousal Disorder: a Biopsychosocial Framework

Jackowich, R. A., & Pukall, C. F.

Purpose of Review
Persistent genital arousal disorder (also referred to as genitopelvic dysesthesia or PGAD/GD) is a distressing and largely underrecognized condition characterized by persistent, unwanted genital arousal (sensations, sensitivity, vasocongestion) in the absence of subjective/cognitive arousal and sexual desire. The purpose of this review is to summarize recent findings on biological and psychosocial factors in PGAD/GD as they pertain to the assessment and treatment of this condition. These findings will be considered within a biopsychosocial framework, for the purposes of considering next steps for clinical and research efforts.

Recent Findings
A small number of studies have recently examined potential biological aetiologies for PGAD/GD: pharmacological agents, spinal pathology and peripheral nerve involvement. Recent studies have also found that PGAD/GD is associated with a significant negative impact on psychosocial wellbeing and daily functioning as compared to symptom-free individuals. In addition, these results highlight cognitive/affective responses to symptoms (e.g. catastrophizing of symptoms) that may influence outcomes. However, biological and psychological research are rarely integrated in these studies, despite the interrelationship between these factors.

Summary
Although PGAD/GD was first described in the scientific literature almost two decades ago, most research on PGAD/GD is presented in the form of case studies. Prospective treatment trials that integrate biopsychosocial factors are needed in order to provide effective and efficient care to this population. This research would be facilitated by the development of a patient-reported outcome measure, as well as greater education/awareness among healthcare providers and the public about this distressing condition.

Jackowich, R. A., & Pukall, C. F. (2020). Persistent Genital Arousal Disorder: a Biopsychosocial Framework. Current Sexual Health Reports, 1-9. [retrieved 11/10/2020]: https://link.springer.com/article/10.1007/s11930-020-00268-2

Covid-19 as Cultural Trauma

Demertzis, N., & Eyerman, R

This paper has two aims. The first is to introduce the concept of compressed cultural trauma, and the second is to apply the theory of cultural trauma in two case studies of the current covid-19 pandemic, Greece and Sweden. Our central question is whether the pandemic will evolve into a cultural trauma in these two countries. We believe the pandemic presents a challenge to cultural trauma theory, which the idea of compressed trauma is meant to address. We conclude that, while the ongoing covid-19 pandemic has had traumatic consequences in Sweden and Greece, it has not evolved into cultural trauma in either country.

Demertzis, N., & Eyerman, R. (2020). Covid-19 as cultural trauma. American Journal of Cultural Sociology, 1-23. [retrieved 11/10/2020]: https://link.springer.com/article/10.1057/s41290-020-00112-z

Social Touch Promotes Iinterfemale Communication via Activation of Parvocellular Oxytocin Neurons

Tang, Y., Benusiglio, D., Lefevre, A., Hilfiger, L., Althammer, F., Bludau, A., ... & Kirchner, M. K.

Oxytocin (OT) is a great facilitator of social life but, although its effects on socially relevant brain regions have been extensively studied, OT neuron activity during actual social interactions remains unexplored. Most OT neurons are magnocellular neurons, which simultaneously project to the pituitary and forebrain regions involved in social behaviors. In the present study, we show that a much smaller population of OT neurons, parvocellular neurons that do not project to the pituitary but synapse onto magnocellular neurons, is preferentially activated by somatosensory stimuli. This activation is transmitted to the larger population of magnocellular neurons, which consequently show coordinated increases in their activity during social interactions between virgin female rats. Selectively activating these parvocellular neurons promotes social motivation, whereas inhibiting them reduces social interactions. Thus, parvocellular OT neurons receive particular inputs to control social behavior by coordinating the responses of the much larger population of magnocellular OT neurons.

Tang, Y., Benusiglio, D., Lefevre, A., Hilfiger, L., Althammer, F., Bludau, A., ... & Kirchner, M. K. (2020). Social touch promotes interfemale communication via activation of parvocellular oxytocin neurons. Nature Neuroscience, 23(9), 1125-1137. [retrieved 11/10/2020]: https://www.nature.com/articles/s41593-020-0674-y

ADHD as a Risk Factor for Infection with Covid-19

Merzon, E., Manor, I., Rotem, A., Schneider, T., Vinker, S., Golan Cohen, A., ... & Green, I.

Background: ADHD limits the ability to comply with Covid-19 prevention recommendations. We hypothesized that ADHD constitutes a risk factor for Covid-19 infection and that pharmacotherapy may lower that risk.

Methods: Study population included all subjects (N=14,022) registered with Leumit Health Services between February 1st and April 30, 2020, who underwent at least one Covid-19 test. Data was collected from the electronic health records. Purchasing consecutively at least three ADHD-medication-prescriptions during the past year was considered drug-treatment.

Results: A total of 1,416 (10.1%) subjects (aged 2months–103years) were Covid-19-positive.They were significantly younger, and had higher rates of ADHD (adjOR 1.58 (95% CI 1.27–1.96, p<.001) than Covid-19-negative subjects. The risk for Covid-19-Positive was higher in untreated-ADHD subjects compared to non-ADHD subjects [crudeOR 1.61 (95% CI 1.36–1.89, p<.001)], while no higher risk was detected in treated ones [crudeOR 1.07 (95% CI 0.78–1.48, p=.65)].
Conclusion: Untreated ADHD seems to constitute a risk factor for Covid-19 infection while drug-treatment ameliorates this effect.

Merzon, E., Manor, I., Rotem, A., Schneider, T., Vinker, S., Golan Cohen, A., ... & Green, I. (2020). ADHD as a risk factor for infection with Covid-19. Journal of Attention Disorders, 1087054720943271. [retrieved 11/10/2020]: https://journals.sagepub.com/doi/full/10.1177/1087054720943271

Effect of Combat Exposure and Posttraumatic Stress Disorder on Telomere Length and Amygdala Volume

Kang, J. I., Mueller, S. G., Wu, G. W., Lin, J., Ng, P., Yehuda, R., ... & Hammamieh, R.

Background

Traumatic stress can adversely affect physical and mental health through neurobiological stress response systems. We examined the effects of trauma exposure and posttraumatic stress disorder (PTSD) on telomere length, a biomarker of cellular aging, and volume of the amygdala, a key structure of stress regulation, in combat-exposed veterans. In addition, the relationships of psychopathological symptoms and autonomic function with telomere length and amygdala volume were examined.

Methods

Male combat veterans were categorized as having PTSD diagnosis (n = 102) or no lifetime PTSD diagnosis (n = 111) based on the Clinician-Administered PTSD Scale. Subjects were assessed for stress-related psychopathology, trauma severity, autonomic function, and amygdala volumes by magnetic resonance imaging.

Results

A significant interaction was found between trauma severity and PTSD status for telomere length and amygdala volume after adjusting for multiple confounders. Subjects with PTSD showed shorter telomere length and larger amygdala volume than those without PTSD among veterans exposed to high trauma, while there was no significant group difference in these parameters among those exposed to low trauma. Among veterans exposed to high trauma, greater telomere shortening was significantly correlated with greater norepinephrine, and larger amygdala volume was correlated with more severe psychological symptoms and higher heart rates.

Conclusions

These data suggest that the intensity of the index trauma event plays an important role in interacting with PTSD symptomatology and autonomic activity in predicting telomere length and amygdala volume. These results highlight the importance of trauma severity and PTSD status in predicting certain biological outcomes.

Kang, J. I., Mueller, S. G., Wu, G. W., Lin, J., Ng, P., Yehuda, R., ... & Hammamieh, R. (2020). Effect of combat exposure and posttraumatic stress disorder on telomere length and amygdala volume. Biological Psychiatry: Cognitive Neuroscience and Neuroimaging. [retrieved 11/10/2020]: https://www.sciencedirect.com/science/article/abs/pii/S2451902220300768

Epigenetic Alterations Associated with Childhood Trauma and Adult Mental Health Outcomes: A Systematic Review

Nöthling, J., Malan-Müller, S., Abrahams, N., Hemmings, S. M. J., & Seedat, S.

Objectives: Multiple, chronic and repeated trauma exposure in childhood is associated with adverse mental health outcomes in adulthood. In this paper we synthesise the literature on epigenetic modifications in childhood trauma (CT) and the mediating effects of differential epigenetic mechanisms on the association between CT and the later onset of psychiatric disorders.

Methods: We reviewed the literature up to March 2018 in four databases: PubMed, Web of Science, EBSCOhost and SCOPUS. Non-human studies were excluded. All studies investigating CT exposure both in healthy adults (18 years and older) and adults with psychiatric disorders were included.

Results: Thirty-six publications were included. For mood disorders, methylation of the glucocorticoid receptor NR3C1 gene, specifically at the NGFI-A binding site in exon 1F, and correlation with CT was a robust finding. Several studies documented differential methylation of SLC6A4, BDNF, OXTR and FKBP5 in association with CT. Common pathways identified include neuronal functioning and maintenance, immune and inflammatory processes, chromatin and histone modification, and transcription factor binding.

Conclusions: A variety of epigenetic mediators that lie on a common pathway between CT and psychiatric disorders have been identified, although longitudinal studies and consistency in methodological approach are needed to disentangle cause and effect associations.

Nöthling, J., Malan-Müller, S., Abrahams, N., Hemmings, S. M. J., & Seedat, S. (2020). Epigenetic alterations associated with childhood trauma and adult mental health outcomes: a systematic review. The World Journal of Biological Psychiatry, 21(7), 493-512. [retrieved 11/10/2020]: https://www.tandfonline.com/doi/abs/10.1080/15622975.2019.1583369

Trauma Does Not Quarantine: Violence During the Covid-19 Pandemic

Hatchimonji, J. S., Swendiman, R. A., Seamon, M. J., & Nance, M. L.

The carnage continued. "Trauma Alert. Police drop off. GSW. ETA now." It was the fourth overhead page in the last 2 hours. One gunshot (GSW) victim was already on the operating room table for repair of a major vascular injury; another was being wheeled upstairs for an urgent thoracotomy after being shot in the chest. The next had arrived pulseless, unable to be resuscitated in the trauma bay. Now the fourth. More surgeons came in from home. This was a Sunday afternoon. All nonessential businesses were closed, and Philadelphia County remained under a "Stay At Home" order. But the trauma alert pages did not stop.

Hatchimonji, J. S., Swendiman, R. A., Seamon, M. J., & Nance, M. L. (2020). Trauma does not quarantine: Violence during the Covid-19 pandemic. Annals of Surgery. [retrieved 11/10/2020]: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7224619/

Telomere Shortening as a Stress-Related Biomarker in Children Exposed to Maternal Chronic Stress In-Utero Measured 7 Years After the Great East Japan Earthquake

Takahashi, S., Arima, H., Nakano, M., Ohki, T., Morita, J., Tabata, K., ... & Yamamoto, T.

Seven years after the Great East Japan Earthquake, we investigated telomeres as a potential biomarker of maternal chronic stress in children according to the timing of exposure to the disaster. The subjects were children aged 5-9 years living in Rikuzentakata, Japan. Relative telomere length (rTL) was measured with PCR in saliva samples. The partial regression coefficient of the rTL was significantly shorter in the group of children conceived after the disaster than in the children who were in utero on the day of the disaster. Telomere length should be investigated as a biomarker for assessing disaster-related trauma in future studies.

Takahashi, S., Arima, H., Nakano, M., Ohki, T., Morita, J., Tabata, K., ... & Yamamoto, T. (2020). Telomere shortening as a stress-related biomarker in children exposed to maternal chronic stress in utero measured 7 years after the Great East Japan Earthquake. Psychiatry Research, 113565. [retrieved 11/10/2020]: https://www.sciencedirect.com/science/article/abs/pii/S0165178120332261

COVID-19 and Human Trafficking - The Amplified Impact on Vulnerable Populations

Todres, J., & Diaz, A.

The coronavirus disease 2019 (COVID-19) pandemic has not only revealed inequities, it has also exacerbated them. Already-vulnerable populations are bearing the brunt of the health impacts of COVID-19 and also experiencing educational and economic consequences. This amplified impact of COVID-19 on vulnerable populations has important implications for individuals at risk of or exploited in human trafficking.

Human trafficking inflicts a breadth of harms on those exploited, including physical, emotional, and sexual violence.1 The COVID-19 pandemic has created circumstances that may increase the risk of trafficking, inhibit identification of those who are trafficked and those who survive trafficking, and make it harder to deliver comprehensive services to support survivors' recovery.

Todres, J., & Diaz, A. (2020). COVID-19 and human trafficking—the amplified impact on vulnerable populations. JAMA pediatrics. [retrieved 11/10/2020]: https://jamanetwork.com/journals/jamapediatrics/article-abstract/2770536

Intergenerational Effects of Childhood Maltreatment: A Systematic Review of the Parenting Practices of Adult Survivors of Childhood Abuse, Neglect, and Violence

Greene, C. A., Haisley, L., Wallace, C., & Ford, J. D.

A history of maltreatment in childhood may influence adults' parenting practices, potentially affecting their children. This systematic review examines 97 studies investigating associations of parental childhood victimization with a range of parenting behaviors that may contribute to the intergenerational effects of abuse: abusive parenting, problematic parenting, positive parenting, and positive parental affect. Key findings include: (1) parents who report experiencing physical abuse or witnessing violence in the home during childhood are at increased risk for reporting that they engage in abusive or neglectful parenting; (2) a cumulative effect of maltreatment experiences, such that adults who report experiencing multiple types or repeated instances of victimization are at greatest risk for perpetrating child abuse; (3) associations between reported childhood maltreatment experiences and parents' problematic role reversal with, rejection of, and withdrawal from their children; (4) indirect effects between reported childhood maltreatment and abusive parenting via adult intimate partner violence; and (5) indirect effects between reported childhood maltreatment and lower levels of positive parenting behaviors and affect via mothers' mental health. Thus, childhood experiences of maltreatment may alter parents' ability to avoid negative and utilize positive parenting practices. Limitations of this body of literature include few prospective studies, an overreliance on adults' self-report of their childhood victimization and current parenting, and little examination of potentially differential associations for mothers and fathers.

Greene, C. A., Haisley, L., Wallace, C., & Ford, J. D. (2020). Intergenerational effects of childhood maltreatment: A systematic review of the parenting practices of adult survivors of childhood abuse, neglect, and violence. Clinical psychology review, 101891. [retrieved 11/10/2020]: https://www.sciencedirect.com/science/article/abs/pii/S0272735820300799

The Rise of Adverse Childhood Experiences During the COVID-19 Pandemic

Bryant, D. J., Oo, M., & Damian, A. J.

Adverse childhood experiences, which is defined by different forms of abuse, neglect, and household dysfunction occurring before the age of 18 years, is a major public health problem in the United States that has the potential to worsen in the current COVID-19 pandemic. Moreover, the challenge is even greater for children and youth from low-income communities and communities of color. Thus, there is a greater need for investments in youth-serving systems within and beyond health care and public health to effectively address adverse childhood experiences and prevent its short- and long-term negative health and social sequelae well beyond the current public health crisis.

Bryant, D. J., Oo, M., & Damian, A. J. (2020). The rise of adverse childhood experiences during the COVID-19 pandemic. Psychological Trauma: Theory, Research, Practice, and Policy. [retrieved 11/10/2020]: https://psycnet.apa.org/fulltext/2020-43450-001.pdf

Female Sexual Arousal during Rape: Implications on Seeking Treatment, Blame, and the Emotional Experience

Bunderson, K.

Currently, survivors' experience during sexual assault is underrepresented in the literature especially regarding survivors who claim that they unwillingly became aroused during the assault. This lack of research may be due to the risk that it may seem accusatory or fear that it will harbor more self-blame and shame in an individual who is already experiencing immense blame and shame. It seems negligent to ignore this real experience that some sexual assault survivors experience and not allow them a platform to express their experience. The aim of this study was to compare females who experienced sexual arousal during their sexual assault to those who did not and assess their treatment seeking behaviors, different forms of blame, and their overall emotional experience. Female sexual assault survivors between the ages of 18 to 50 years old completed an online survey through Qualtrics and were placed into two separate groups (N = 166; 115 in the non-aroused group; 51 in the aroused group). There were no significant group differences in regards to help-seeking behaviors, satisfaction with one's therapist, self- blame, blame placed on the rapist, and control over the recovery process. There was statistical evidence that those who were sexually aroused told significantly fewer people about their sexual assault compared to those who did not endorse sexual arousal. These findings provide evidence that female sexual arousal is an actual experience and should no longer be spoken about anecdotally. Clinicians are encouraged to initiate the topic of arousal with their patients and emphasize that it is a natural, physical response in hopes to reduce any shame and blame that accompanies different rape myths.

Bunderson, K. (2020). Female Sexual Arousal during Rape: Implications on Seeking Treatment, Blame, and the Emotional Experience (Doctoral dissertation, Alliant International University). [retrieved 11/10/2020]: https://search.proquest.com/openview/609e307a4f4aae51800e84d14e013a68/1?pq-origsite=gscholar&cbl=18750&diss=y

COVID-Related Family Separation and Trauma in the Intensive Care Unit

Montauk, T. R., & Kuhl, E. A.

Due to stringent but necessary infection control mandates, the COVID-19 pandemic is increasingly resulting in family separation from loved ones admitted to intensive care units (ICUs). Even in normal circumstances, ICU families frequently experience significant psychological dysfunction—including posttraumatic stress disorder and other trauma-related reactions, especially during the end of life period. The COVID pandemic likely will exacerbate these reactions as more and more families are being barred from the ICU. Consequently, ICU families are facing additional barriers in fully understanding the complex medical needs of their loved ones (and hence being able to make informed care decisions on their behalf); establishing rapport and bonding with nurses and other members of the ICU treatment team; and, in the event that a loved one passes, achieving closure. ICU health care providers can take steps to mitigate these outcomes by being mindful of the unique stressors ICU families are currently facing and tailoring their communication and behavior accordingly.

Montauk, T. R., & Kuhl, E. A. (2020). COVID-related family separation and trauma in the intensive care unit. Psychological Trauma: Theory, Research, Practice, and Policy. [retrieved 11/10/2020]: https://psycnet.apa.org/fulltext/2020-44806-001.html

Childhood Trauma, Addiction & a Modernized Approach to Treatment

Symonds, L. J.

This review serves to analyze the relationship between childhood trauma and addiction; provide an overview of the science behind addiction; analyze issues with current addiction treatment methods and protocols; as well as to provide a list of proposed changes to modernize addiction treatment to a level of quality which will prove much more successful in the treatment of addicts.

Symonds, L. J. (2020). Childhood trauma, addiction & a modernized approach to treatment. Life Research, 3(4), 176-182. [retrieved 11/10/2020]: https://www.tmrjournals.com/uploads/soft/201025/Childhoodtrauma,addiction&amodernizedapproachtotreatment.pdf

Childhood Trauma, Personality, and Substance Use Disorder: The Development of a Neuropsychoanalytic Addiction Model

Fuchshuber, J., & Unterrainer, H. F.

Background

While traditional psychoanalysis has been criticized as insufficient for the treatment of substance use disorder (SUD), recent progress in the field of neuropsychoanalysis has generated new and promising hypotheses regarding its etiology. However, empirical research applying this framework has been sparse.

Aim and Scope

The present overview aims at developing and empirically validating a neuroscientifically informed psychodynamic framework regarding the etiology of SUD. For this purpose, this review provides a concise overview of the most relevant historical and contemporary psychoanalytic theories on SUD etiology. Furthermore, the original research summarized in this paper consists of three studies investigating connections between childhood trauma, primary emotions, personality structure and attachment, as well as their relation to SUD development and treatment.

Conclusions

The results highlight the empirical validity of the neuropsychoanalytic approach towards SUD etiology. In particular, the findings underscore the conceptualization of SUD as a disorder related to dysfunctional attachment and affect regulation abilities especially linked to increased SADNESS and ANGER dispositions, which mediated the relationship between SUD and traumatic childhood relationships. Based on these findings, a refined model of SUD etiology is proposed, which should be tested in future studies.

Fuchshuber, J., & Unterrainer, H. F. (2020). Childhood Trauma, Personality, and Substance Use Disorder: The Development of a Neuropsychoanalytic Addiction Model. Frontiers in Psychiatry, 11. [retrieved 11/10/2020]: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7296119/

The EMDR Recent Birth Trauma Protocol: A Pilot Randomised Clinical Trial after Traumatic Childbirth

Chiorino, V., Cattaneo, M. C., Macchi, E. A., Salerno, R., Roveraro, S., Bertolucci, G. G., ... & Fernandez, I.

Objective: This pilot study investigated the effectiveness of brief EMDR intervention as compared to treatment-as-usual (TAU) in women with post-partum PTSD symptoms.

Design: A pilot randomised controlled trial was conducted to evaluate possible differences between one EMDR session (n=19) and one TAU session (n=18) delivered in a maternity ward in the aftermath of childbirth.

Main Outcome Measures: The primary outcome measure was the rate of remission of post-partum post-traumatic stress symptoms (i.e. IES-R score <23) in both groups at 6-weeks (T1) and 12-weeks' post-partum (T2). Secondary outcome measures were mother-to-infant bonding, post-partum depressive symptoms,

the presence of flashbacks and level of distress.

Results: Most of the women improved their post-partum post-traumatic stress symptoms after only one treatment session. EMDR resulted more effective than TAU in reducing the proportion of women with post-partum post-traumatic stress symptoms at 6-weeks' post-partum (78.9% EMDR vs. 39.9% TAU; p = .020). Moreover, women treated with EMDR experienced less flashbacks and distress as compared to TAU. No significant difference was found between treatments on mother-to-infant bonding and post-partum depressive symptoms.

Conclusions: These findings, although preliminary, suggest that a brief EMDR intervention could be a viable and promising tool in the early treatment of post-traumatic stress related to traumatic childbirth.

Chiorino, V., Cattaneo, M. C., Macchi, E. A., Salerno, R., Roveraro, S., Bertolucci, G. G., ... & Fernandez, I. (2020). The EMDR Recent Birth Trauma Protocol: a pilot randomised clinical trial after traumatic childbirth. Psychology & health, 35(7), 795-810. [retrieved 11/10/2020]: https://www.tandfonline.com/doi/abs/10.1080/08870446.2019.1699088

DATES FOR YOUR DIARY IN 2021

January 23, 2021
TRC Conference 2021: Complex Trauma and Dissociation. Trauma Recovery Centre (TRC).
https://www.eventbrite.co.uk/e/trc-conference-2021-complex-trauma-and-dissociation-tickets-63441342764

March 19-21, 2021
Workshop: From Early Attachment to Borderline Personality Disorder: Traumatic Attachment and Dissociation. Fortshritte Hamburg. https://www.fortschritte-hamburg.de/referent-innen/tutor/36

Virtual. Pre-Conference: April 9, 2021 | Main Conference: April 10-12, 2021
ISSTD 38th Annual Conference – The World Congress on Intergenerational Trauma
Conference Website: https://annualconference.isst-d.org/

11-13 June, 2021
EMDR Europe Research & Practice Conference. Dublin, 11-13 June, 2012.
Web: https://emdr2021.com/programme/

November 4-6, 2021.
EMDR et troubles de la personnalité. Institut romand de psychotraumatologie (IRPT). Lausanne.
https://www.irpt.ch/fr/agenda?event=385

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

Events from the ISSTD online:

Thursdays: Jan 14, Feb 11, Mar 11, May 6, June 10, July 8, 2021
The Complexities of Complex Trauma Part I
Instructor: Gary Peterson
Time: 6:30pm - 9:00pm US Eastern Time

Thursdays: Jan 28, Feb 25, Mar 25, Apr 22, May 20, June 24, Jul 22, Aug 26, 2021
From Complex Trauma to Dissociative Disorders Part I
Instructor: Gary Peterson
Time: 6:30pm - 9:00pm US Eastern Time

Jan 7, Jan 28, Feb 25, Mar 25, Apr 15, May 6, May 27, June 17, 2021
From Complex Trauma to Dissociative Disorders Part II
Instructors: Su Baker and John O'Neil
Time: 7:00 PM - 9:30 PM Eastern Time

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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