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ESTD NEWSLETTER

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QUARTERLY QUOTE

Orit Badouk Epstein

"Eventually when a glimpse of freedom from the past begins to show, the division of the personality becomes more permeable and the tension between being and becoming begins to unfold. The healing process is never a static structure but a non-linear process of repetitive negotiation between what is lost and what is earned. After all, in life, everything apart from death involves repetition. Yet, with each repetition we gain something new. In attachment terms, earned security is the process of mobilising repetition towards affect regulation, maturation, and renewed trust."

(Orit Badouk Epstein (2021, p. 166; in Shame matters: Attachment and relational perspectives for psychotherapists. London & New York: Routledge.)

Raphaël Gazon
ESTD President

LETTER FROM THE PRESIDENT

Dear Colleagues and Fellow Members of ESTD,

The end of the year is approaching, and winter is setting in - it's time to take stock of 2021 and prepare for the year to come.

As you already know, this year ESTD has launched a series of webinars on the central dimensions and concepts related to the diagnosis of trauma and dissociation.

Two webinars have been held since the return to work. On 16 September 2021, we invited Professors Vedat Sar and Martin Dorahy to discuss the many faces of dissociation and cross-identity amnesias found in patients with Dissociative Identity Disorder.

In addition, on 14 October 2021, we were pleased to welcome Professors Contanze Dalenberg and Simone Reinders to discuss the scientific arguments supporting the relationship between trauma and dissociation, and the validity of Dissociative Identity Disorder.

Following their brilliant scientific demonstrations, the speakers answered numerous questions from the participants, allowing them to explore the issues in greater depth.
I would now invite you to take your diary and note the dates of the next two webinars which will take place in early 2022.

On 20 January 2022, from 19:00 to 20:30 (Berlin, Europe, CEST), we will start the year with a presentation by Suzette Boon on the assessment of dissociative disorders. She will present Trauma and Dissociation Symptoms Interview (TADS-I).

On 17 March 2022, from 19:00 to 20:30 (Berlin, Europe, CEST), we will follow up with a lecture by Professor Richard Loewenstein entitled Dissociative Disorders and Differential Diagnoses.

Alongside our webinars, the scientific journal of our association (EJTD) is doing well and is beginning to gain recognition in the scientific community. It was recently indexed in PsycInfo and can now be found in 3 databases:

1) Scopus: https://www.elsevier.com/solutions/scopus/how-scopus-works/content

2) Web of Science WoS / Emerging Sources Citation Index / ESCI: - https://clarivate.com/webofsciencegroup/solutions/webofscience-esci/

3) PsycINFO: https://www.apa.org/pubs/databases/psycinfo

As a reminder, you can access our journal directly via the menu on the ESTD website (https://www.estd.org/how-access-estd-journal) .

Another important piece of news that will mark the beginning of 2022, and that will please fans of Pierre Janet, is the translation into English of L'automatisme Psychologique (Pierre Janet, 1989). It is one of the earliest and most important books written on the study of trauma and dissociation. It will be available for the first time in English, with a preface by Giuseppe Craparo and Onno van der Hart: Catalepsy, Memory and Suggestion in Psychological Automatism: Total Au (routledge.com). Now there's a great gift for Christmas!

Finally, in my previous letter, I announced the next ESTD congress in Brussels in October 2022. This congress will unfortunately be postponed until Spring 2023, as no venue could be found at a reasonable price. We are still working hard to finalise a date and put together an exciting programme for you. I hope to be able to give you clear and definitive information in the coming quarter!

I will end my letter by wishing you a Happy Holiday season and by sending you my best wishes for the year 2022.

Thank you again for your support!

Raphaël Gazon
President, ESTD

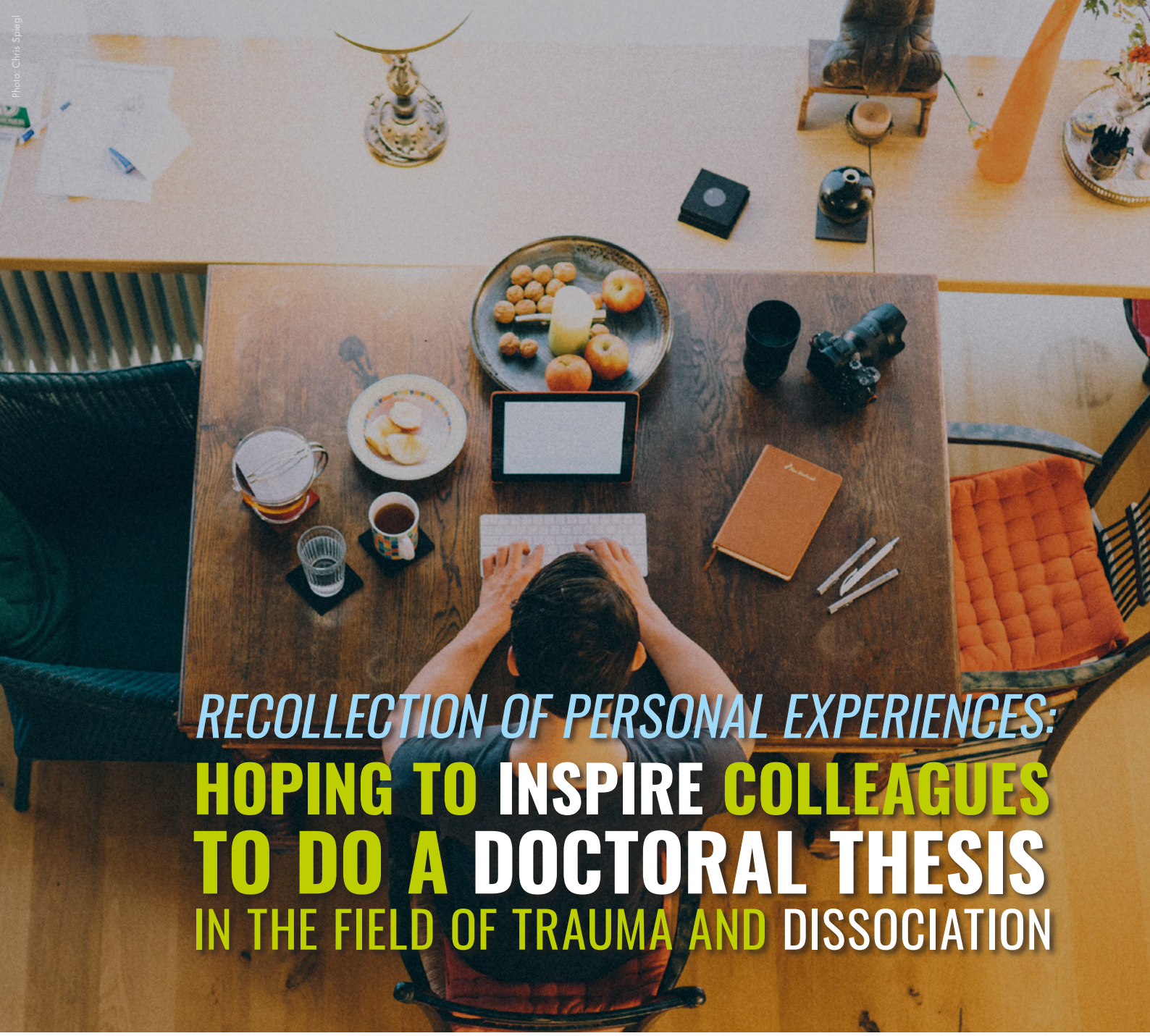

Photo: Chris Spiegl

RECOLLECTION OF PERSONAL EXPERIENCES: HOPING TO INSPIRE COLLEAGUES TO DO A DOCTORAL THESIS IN THE FIELD OF TRAUMA AND DISSOCIATION

By: Olivier Piedfort-Marin

In the last edition of the ESTD Newsletter, Camille Tarquinio had the kindness to present a summary of the thesis that I defended last March 2021 at the University of Lorraine, Department of Psychology, in Metz, France (Piedfort-Marin, 2021). Onno van der Hart asked me to share, in an article intended for the ESTD Newsletter, my experiences and recommendations regarding working on a thesis on the topic of dissociative disorders, so as to be a source of inspiration for other clinicians with an interest in research in our field.

How it started

It all started with an apparently "beside" comment from Prof Cyril Tarquinio after he read a paper that I, as a clinician specialized in the treatment of trauma-related disorders, including dissociative disorders, had written in French in 2017. "You should give your work more visibility", he said. I did not know what he meant until he explained to me that I should do a thesis under his direction. Cyril Tarquinio is Professor of Psychology at the University in Metz; he has set up

a Master degree in psychotraumatology, University diplomas in EMDR, and he is the director of the Centre Pierre Janet, a center integrated within the university, providing therapy to patients, training to professionals, and researching in the field of trauma. I was surprised at first by his suggestion, and I did not really know what to think of this proposition. It did not fit in the way I imagined my life. Back then I was at a moment of my career where I had in mind to share things that I had learned by writing clinical articles. I had also embarked in a validity study of the French version of the SCID-D. After a period of doubt, I thought why not have the bonus of a Ph.D. title after the work that I want to do anyhow?! Of course, I learned in the meantime that a Ph.D. is not simply a bonus... In France, at least, and in some other countries as well, experienced clinicians can do a thesis based on a series of articles they have published in selected peer-reviewed journals. The articles must then be integrated in the text of the thesis. I decided early on that my thesis would have a mixed content: an empirical study (the SCID-D research) but also theoretical and clinical articles. I wanted my thesis to be helpful for clinicians and researchers as well, as there is a need for a rapprochement between the two. Experienced clinicians have now the possibility to link a conceptual reflection with their clinical practice in a doctoral thesis. This was a great opportunity that I decided to take.

What would be the theme of my thesis? This was the first question I needed to address., I wanted to fit the ten articles needed for my thesis in a well-structured document that was coherent and with clear, specific aims. I reflected on my years of clinical work since I first heard of dissociation, and I realized that I should give tribute to dissociative disorders. We know that, around the globe, these disorders receive little interest from the scientific community. We know that there is very little money for research in this field. And we know that there are many misconceptions about dissociative disorders. In fact, as I started to prepare the validity study of the French version of the SCID-D back in 2014, my intention was to respond to the needs of colleagues to properly assess dissociative disorders, and the need of dissociative patients to be recognized in their very specific pain and symptoms, for which they should receive the appropriate treatment that they deserve. Another aim was to provide the French-speaking countries with the basic tool for future research in the field, namely a recognized diagnostic instrument. I understood – perhaps incorrectly – that I would not find support from a psychiatric hospital. This is why I decided to monitor this research by myself, with the help of several colleagues who helped with the translation, with the study itself, and with finding some (very limited) funds.

Writing a thesis on the dissociative disorders would mean that these disorders would enter the university. This also meant that the invited members of the jury – some of whom are not specialized in this field – would have to read the thesis and debate it with me. In the context of French psychology and psychiatry, and the dominance of Freudian and Lacanian psychoanalysis in France (an exception which it shares, worldwide, with Argentina, it seems), this was quite a challenge to bring back to France the ideas of Pierre Janet! Colleagues from other countries may not know that Janet has been largely forgotten in his native France. His work hardly appears in the Bachelor's or Master's programs of universities of psychology across this country. While most of Janet's books have been re-published in France, they are even difficult to find in French bookshops! Other countries may be more advanced than France in the rediscovery of Janet and his brilliant work.

Acknowledging, assessing, and treating dissociative disorders

Writing a thesis as an experienced clinician asks you to look back at your career, what you have learned, achieved, missed, what you have failed at, and what you want to learn in the years to come. I hesitated on the subject and the title of my thesis for more than a year. This was not a problem, as you can change the focus of your work in the course of the thesis, but one should be careful not to lose too much time in procrastination. This is actually the process of the thesis: thinking, thinking and reflecting. Trauma

and dissociation are my specialties, but this was much too broad for a thesis. Looking back at the last 15 years of my professional path, I realized that the core of my work had not just been to fight for the recognition of the traumatic origins of mental disorders. I had fought hard and constantly for the recognition of dissociative disorders in my region and beyond, which often led to a feeling of solitude. I have even been called "dissident" in the CBT field at some point … and this was true! Therefore, I decided to use this thesis as an opportunity to give recognition to the dissociative disorders and to the individuals suffering from these conditions. Suddenly, this made complete sense. This implied that I would leave aside articles that I had already published but that would not fit so well in this thesis. This resulted in the need to write more articles than originally planned. But work is not a problem, it is the solution. I had the subject of my thesis and the plan as well. "Acknowledging, Assessing, and Treating Dissociative Disorders": this would be the title of my thesis.

Acknowledging dissociative disorders is a difficult task, not only for psychiatry and psychology in general, but also often for colleagues already interested in trauma-related disorders. The differences with psychosis and schizophrenia, but also with borderline personality disorder, are subjects of battles between researchers and clinicians. Colleagues starting a training in dissociative disorders may become troubled because learning about dissociative disorders obliges them to take a critical look at what they have learned previously. A colleague had once asked me if I could recommend a paper in French on the myths about dissociative identity disorders (DID), that she could present to an insurance expert who had written that DID does not exist. I could not but realize that I could write such an article and that this paper could be valuable for many psychotherapists facing the same difficulties as this colleague. This became the first article presented in my thesis, dealing with the myths about DID (Piedfort-Marin, Rignol, & Tarquinio, 2021). The starting points were the basic assumptions that we often hear in our clinical work when we exchange with colleagues:

- DID is actually schizophrenia;
- There is no such thing as DID;
- DID develops under the influence of the media and/or therapists in people with fantasy proneness and high suggestibility;
- The etiology of DID is therefore iatrogenic and not post-traumatic;
- Amnesia for the terrifying traumatic stories that these individuals later report in therapy is not possible; such stories are baseless inventions.

Although this article was written in French to better target French and Swiss colleagues, it attracted the attention of Prof Steven Jay Lynn and colleagues (Dodier, Lynn, & Otgaar, in press), adherents of the socio-cognitive model of DID, who wrote a critical commentary. Quite flattering as a friend said!

Assessing dissociative disorders is not an easy task and requires validated diagnostic instruments. The SCID-D has been widely used in research and clinical practice in different countries. However, until recently it was not validated in its French version and no other diagnostic instrument was available in France and other francophone countries. In 2014, I decided to do a validation study of the SCID-D. This study was longer than I initially expected. Marlene Steinberg, the author of the SCID-D, decided to take the opportunity to make needed adjustments to the DSM-5 and make it available for colleagues using the ICD categorization system in its 11th version. This added more delay in the development of the latest version of the SCID-D. Our research (Piedfort-Marin, Tarquinio, Steinberg, et al., 2021) is the first one to validate the latest version of the SCID-D (Steinberg, in press) applicable to DSM-5 and ICD-11 diagnostic criteria. I am proud that I could make available to French-speaking colleagues a valuable instrument in assessing dissociative disorders. This will allow clinicians to assess their patients with more precision and accuracy. And foremost, this will help patients in their difficult journey, for example in relation to health insurances, who often expect the use of validated instruments, at least in Switzerland. Managing such a study as a psychotherapist in private practice, with no previous experience in research, is a challenge or a sign of madness. I had the

chance and honor to profit from the help and support of Marlene Steinberg, the study being a replica of previous research on the SICD-D. Cyril Tarquinio dealt with the statistics. Several colleagues agreed to help with and test the translation, and to view and assess the videos as co-raters. Other colleagues simply gave their moral support, or money, which was also necessary. While monitoring such a study is a lonely job, it is a pleasure to remember that many people were involved.

Treating dissociative disorders is a great challenge. In my journey of writing clinical articles, I did not invent anything new. And frankly, I don't think that anyone is inventing anything new anymore in psychotherapy methods and interventions. However, I thought that I might address several points of view possibly useful to other colleagues. My basic theoretical framework is the theory of the structural dissociation of the personality (TSDP; Van der Hart, Nijenhuis, & Steele, 2006/2010). Writing clinical articles on dissociative disorders – possibly even so in the context of a thesis – requires going deeper in the understanding of one's theoretical framework. The TSDP is a far more complex theory than it may appear. Having learned the treatment of dissociative disorders with Ellert Nijenhuis since 2005, I have been trained to integrate the complexity of theoretical concepts in my clinical practice. In the clinical articles that I wrote in the context of my thesis, I was confronted with a conflict of loyalty to Ellert and his teaching. On one hand I knew that there was nothing that I could write that would come close to the genius of his thinking and of his clinical work. On the other. I had to find my own way and be confident about myself, however with no intention of "killing the father"! I hoped to use all that I learned from Ellert and still be myself. This is what the enactive approach (Nijenhuis, 2015, 2017) is all about, in fact. This led to many moments of doubts, but "confusion leads to insight," according to Milton Erikson. Originally, I believed that writing articles on my clinical work could help others. However, I wonder how many colleagues read articles. There are so many things to read! Finally, I discovered that writing expanded my own understanding of my clinical work. It helped me incredibly to integrate the complex theoretical concepts that I learned over the years. This may sound as an immediate selfish goal, but I guess and hope that my patients and supervisees profit from this.

The joy, the doubts, and a few difficulties

In the four years that the thesis took, there were a few difficult moments, of course, but only a few. When a paper is refused by a journal that is supposed to be open to different theoretical and clinical perspectives, it is never easy. When a paper receives harsh – and sometimes unfair – critical reviews, it is not easy either. I realized that writing clinical papers is difficult because you write about very personal experiences, pertaining to relationships between clients and yourself. And then reviewers and readers will judge and comment on this intimacy, not always respectfully. I feel more fragile when a clinical article is criticized because it relates to an intimate experience, this is the way I consider a therapeutic relationship. In fact, one of the articles selected for my thesis relates to trauma-related countertransference and how to use it in therapeutic work with severely traumatized clients (Piedfort-Marin, 2019). I think we do not explore this issue enough in dissociative disorders trainings, or only at a theoretical level. With this article I wanted to transmit real, subjective experiences of trauma-related countertransference, that could be useful to other therapists. That paper was well received by the reviewers, though.

In 2016, the SCID-D study received the approval of the local ethics committee, which was very helpful in assisting to the fulfillment of the requirements as it was the first time that I engaged in such a complex procedure. Since the study had to be postponed until the SCID-D's adaptation to the ICD-11 was done, I announced in 2019 that we could now start the study. I was devastated to learn that the procedures had been changed to a much higher level of requirement: Suddenly I needed to become a lawyer, a data protection specialist, an IT freak, a statistic specialist. I had one month to make all necessary changes. Since I was monitoring this study as a psychotherapist in private practice, I wanted my documents to be irreproachable, and I lacked the support of a large hospital. This is the point when I

almost stopped the SCID-D study; only the sense of duty kept me going. I thought it would be so stupid to stop at this stage, after all that had been done until then. I downloaded the modified documents on the night of my birthday, during a vacation in the South of France, while my friend was peacefully sleeping. Is this a life?! Maybe the ethical procedures related to research are stricter in Switzerland than in other countries, I do not know. I was particularly concerned that, during or after the SCID-D interview, dissociative participants to the study might do what they often do: have a long switch, hurt themselves badly, etc. This would have led to a hospitalization, the opening of a case by the insurance company, and a hold up of the study by the ethics committee for evaluation. In the end, all went well. Of course, participants with DID switched but the adult part could come back in due time. Since this experience, I have the most respect for researchers, even those publishing research that, I believe, is useless.

Apart from these few short but intensely difficult moments, my thesis was a path of pleasure and joy. I discovered that I enjoy writing, I enjoy thinking about concepts and clinical work. Overall, working on my thesis was a very positive experience. This is what I will remember.

The last moment of stress was a few weeks before submitting my final manuscript, during the Christmas holidays: which subtitle should I choose? I was suddenly unhappy with the one I had chosen which I cannot even recall right now! The title of the thesis being broad, it needed a subtitle that would target the specificity and originality of the text. Suddenly, a few weeks before the end of this journey, I had doubts about the meaning of the whole work! My doubts disappeared when I realized what I have been working for during this long journey, since I had discovered dissociative disorders: I have been working on integrating in my clinical practice the concepts and the therapeutic skills that I needed to learn; I have been trying to understand the horrors the patients had lived and what they awakened in me. And I have been helping patients to integrate their traumatic experiences. The subtitle was then clear: "The difficult path towards integration for patients and clinicians."

The older, the better

What is the point of a Ph.D. thesis defended at age 58? I believe that there is a big difference between writing a thesis right after your Master degree and much later after many years of clinical and other experience. The difference lies in the ability for experienced clinicians to combine theoretical and clinical perspectives. The feedback that I received from several colleagues is that my thesis has the advantage of connecting the theoretical and empirical perspectives to the clinical perspective. I believe that older, experienced clinicians can do this better than their younger colleagues.

A thesis is typically a solitary experience, and I enjoy writing alone in my country house, seated by the kitchen table or in the garden under the trees. Nevertheless, it is also an experience of sharing. Of course, Cyril Tarquinio supported me fully as my thesis director. I am indebted to the many people I learned from in different ways. Over the years I had many teachings or in-depth exchanges with many colleagues and experts, particularly with Susanne Leutner, Giovanni Liotti, Andrew Moskowitz, Luise Reddemann, Marlene Steinberg, Onno van der Hart, Eva Zimmermann, and last but – by far – not least Ellert Nijenhuis. All that I learned with these colleagues would have no meaning if it was not for the patients with dissociative disorders and other trauma-related conditions that I work with in therapy, and for the patients of the colleagues who trust me in supervision.

The local development of the literature on dissociative disorders

Researchers are encouraged to publish in English, the only scientifically validated language, it seems! I believe that we will support the cause of diagnosis and treatment of dissociative disorders by publishing in other languages. This is the reason I encourage colleagues from the different European countries to publish in their own language in local scientific journals. This may not bring much glory in one's CV, but may target more directly clinicians who do not speak English, i.e. most of them. This was one of my aims with my thesis which gathers five papers

written in French, three in English, and two published in both languages.
In the Francophone countries, clinicians and researchers have at their disposal:

- Several screening instruments validated in French: SDQ-20, DIS-Q and DES;
- New: a validated diagnostic instrument, the SCID-D, whose publication is in preparation;
- New: a translated and adapted instrument to assess the evolution of the therapy of dissociative disorders (DTMI: Kluft, 1994; Piedfort-Marin, Wisler, Piot, & Spagnoli, 2017).

Unfortunately, colleagues from France and other Francophone countries may not be aware of the richness of Pierre Janet's work which is available to each clinician in its original French version. Janet's language is easily understandable, in contrast to many authors of that period. But at least they have at disposal the theory of the structural dissociation of the personality (Van der Hart et al., 2006/2010), which offers a modern presentation of Janet's conceptual work. This constitutes a theoretical base for clinicians to publish clinical articles in French, which will expand the interest in dissociative disorders among other clinicians.

In the conclusion of my thesis, using the epidemiological data we have about dissociative disorders (Dell, 2009), and the official data from health authorities, I calculated how many individuals may be concerned in France and in Switzerland. In France (67 million inhabitants) there may be between 42.000 and 84.000 individuals with a severe dissociative disorder (DID and partial DID) hospitalized in 2019, and around 1.827.000 treated in outpatient facilities. This does not include patients being treated in private practice. In Switzerland (with 8.5 million inhabitants) there may be 41.000 (most reasonable figure) patients suffering from a severe dissociative disorder (in- and outpatient facilities and private practices). These figures raise concern in a more concrete way. With so many individuals with a (severe) dissociative disorder, why are these disorders not listed in the official data of mental health institutions? These figures are easy to calculate, and I encourage the ESTD representatives from each country to reply to this question: How many individuals/patients have a dissociative disorder in your country? Then you may have some basic data, helpful when you want to discuss with the health authorities about the needs of these patients. This is the next step I intend to engage in, in my region, the French-speaking part of Switzerland.
In the field of dissociative disorders, it is very nice to meet at our conferences and publish in specialized journals like the European Journal of Trauma and Dissociation, but we need to be "out there" where we are not expected to be. A doctoral thesis gives this opportunity: to push closed doors and bring dissociative disorders into the universities.
I hope that by sharing my experiences, colleagues will consider doing a thesis that will address one of the many issues of trauma and dissociation. For me the work was worth it, definitely! This is an extraordinary way to increase even more one's knowledge in the field, and to move forward the recognition of trauma-related disorders and dissociative disorders. There should be many to invade universities with such a project. Just do it!

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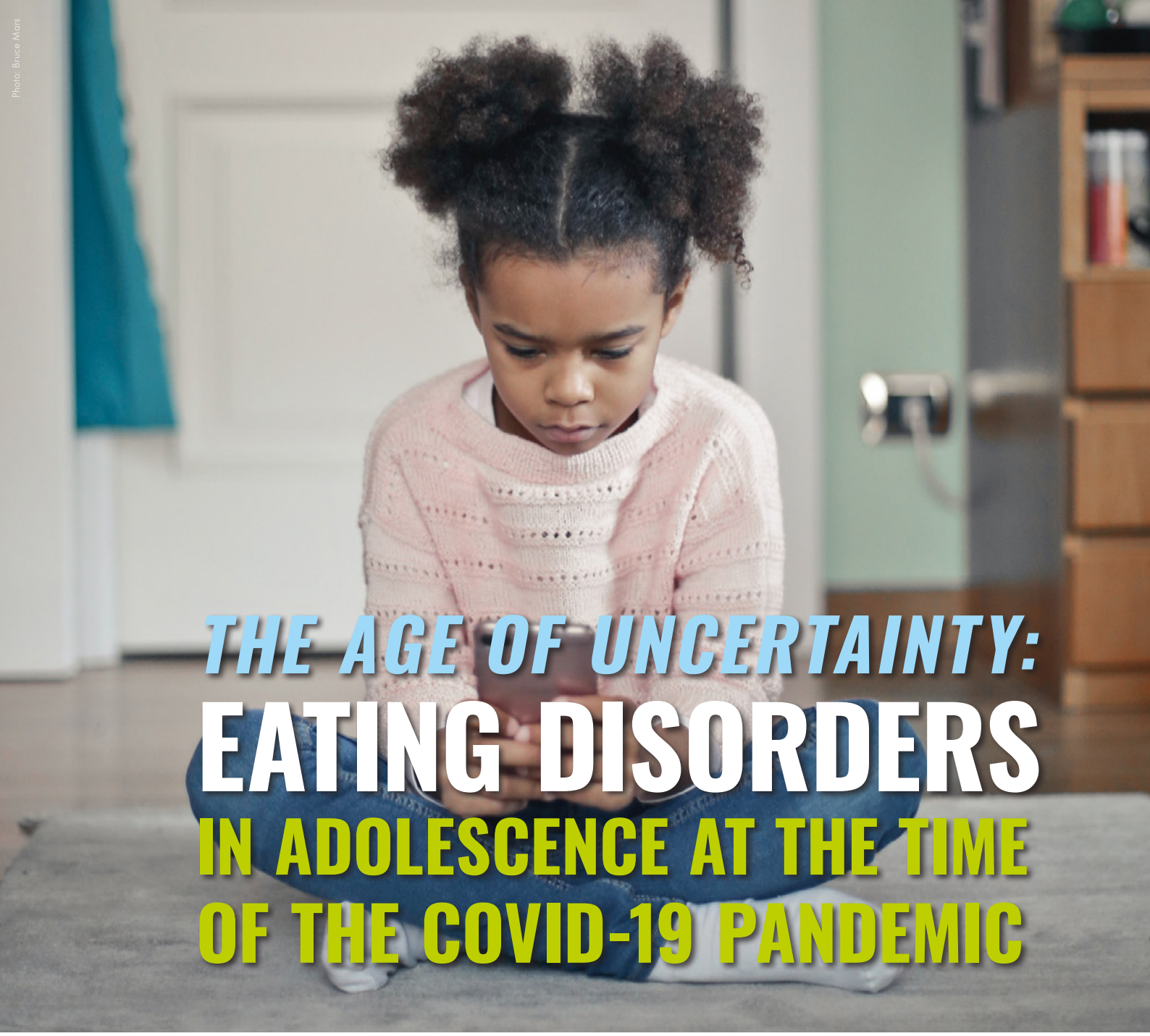

Photo: Bruce Mars

THE AGE OF UNCERTAINTY: EATING DISORDERS IN ADOLESCENCE AT THE TIME OF THE COVID-19 PANDEMIC

By: Armando Cotugno

When the Covid-19 pandemic started last March, kids had their lives uprooted, as remote schooling, separation from friends and family, and the lack of structure during quarantine became major lifestyle changes. In addition to navigating these changes, children and teens have lived in a state of constant unknowns. One of the biggest stressors prior to the pandemic was uncertainty: since March 2020 uncertainty is the first game that children and adolescents have been playing in their everyday life (Guessoum et al., 2020). During the Covid-19 crisis, combining puberty with high anxiety and uncertainty, a lack of structure, and constant pressure from increased engagement with social media were an onslaught of risk factors placed on young people: that's pretty much a perfect storm for developing an eating disorder (Fernández-Aranda et al., 2020). The reasons why children or adolescents may develop an eating disorder are multifactorial, but the pandemic has left many young people isolated, uncertain about the future and less in control (Cotugno, 2021; D'Ambrosio, 2021).

Valentina, a 13-year-old girl, was always lively and outgoing, very active both in school and sports activities. However, following the restrictive measures imposed by the pandemic (March 2020), she was forced to spend a lot of time alone at home. As an only child, she began to feel more and more bored, and she started to spend most of her time on her smartphone. After some time, she showed a moderate weight gain. With the end of the first lockdown (May 2020), Valentina partially resumed her vibrant social life; she graduated from middle school and happily spent the summer holidays with her family. Shortly after the beginning of high school (September 2020), Italy was struck by a second lockdown, during which Valentina developed anxiety, depressive symptoms, and sleep disturbances (insomnia). In November 2020, both Valentina and her parents contracted the Covid-19 infection. The girl remained asymptomatic, while her mother and father developed a mild respiratory disorder with complete remission of symptoms. With the arrival of the Christmas holidays, Valentina became progressively more worried about her weight and body image. As a result, she began to restrict her caloric intake, losing fourteen kilos in only six weeks. In March 2021, she was admitted to Bambino Gesù Pediatric Hospital of Rome following a severe bradycardia episode associated with lipothymia. While hospitalized, Valentina received enteral nutrition through a nasogastric tube due to her malnutrition. After her discharge from the Pediatric Hospital, she was an outpatient at the Eating Disorder Unit, ASL RM1. Her story echoes that of many teenagers experiencing isolation and anxiety during the pandemic, spending hours every day in online classes, posting more on social media. Many may also have lost access to their usual routines and coping mechanisms: since the pandemic began, isolation, anxiety and hours upon hours of screen time have led to a surge in eating disorders among adolescents.

In Spring 2020, researchers and clinicians expressed concerns for the mental health of youth as the impacts of the Covid-19 pandemic took hold. Among those were concerns for individuals with eating disorders. As a clinician and Director of the Eating Disorder Unit, ASL RM1 in Rome, I worried about the impact of increased social isolation on individuals with an illness that is inherently isolating. My colleagues and I worried that the severity of an adolescent's eating disorder would worsen under such stressful circumstances and that the risk of relapse among patients would increase. And as food insecurity, economic hardships and family struggles began to weigh upon households, our concerns for these vulnerable youth grew: the recent data coming from all Europe and USA tell us that our concerns were well-founded (Canadian Consensus Panel, 2020).

We have observed a significant increase in the number of adolescents with new onset eating disorders coming to the emergency room and to our outpatient clinic. In line with data coming from other countries, in Rome we observed a rapid 60%-70% increase in the number of youths seeking treatment of an eating disorder: the pandemic is as if Pandora's Box opened, making the presence of eating disorders among adolescents more visible. In both the severity of the eating disorder and the number of people struggling, we've experienced a big increase in not only the volume of eating disorder patients, but also the number who are medically compromised due to malnutrition. While we were used to seeing patients who lost between 5 and 10 kilograms in a few months, we now see a higher frequency who have lost up to 20-25 kilos in a few months! More research is ongoing to quantify this wave of new onset or newly identified eating disorders among youth worldwide. While it will take some time to truly understand the effects of Covid-19 on the mental health of youths, we know that it has been indisputably impacted. Over the past year, the young have been isolated from friends, many are not attending in-person school full time, extracurricular activities are canceled or significantly impacted and social media use has increased. Many young people had had nothing to do during the first lockdown and so focused on healthy eating – which in some cases developed into an unhealthy obsession, and then into a diagnosable eating disorder (Cooper et al., 2020).

As kids in isolation have turned to TikTok and Instagram for their social interactions, they're likely exposed to constant messaging about losing weight. The pandemic has limited the number of people that kids see each day, and their understanding of body image diversity can become biased towards what they see online: it starts to skew the understanding of what normal looks like. Teens are being inundated with content about how to avoid the "quarantine 15," or take advantage of free time to adopt a new exercise regimen. Changing diet to lose weight or to keeping off the so-called "COVID 15" (gaining weight -15 pounds- during the quarantine) or increasing exercise to "get fit" or "stay in shape" for sport can seem innocuous to many, but for adolescents at risk of developing an eating disorder, weight loss for any reason can open the door to the development of severe medical and psychiatric illness.

Adolescents are growing, their brains are developing and their bodies are building bones and muscles. Their bodies should continue to gain weight through adolescence into early adulthood. Any significant change in eating or exercise behavior in an adolescent should be cause for concern, as should any weight loss. If a child falls off their historical growth curves it is important to take a hard look at their behavior. Concern about their weight, a reduction in the types of food they normally eat (e.g., cutting out sugar, reducing carbohydrates, becoming a vegetarian), and increasing exercise without increasing the fuel needed to exercise are all red flags that the weight loss or behavior is not healthy. For individuals with a genetic predisposition, weight loss can trigger the development of an eating disorder. Once you've developed an eating disorder, you've now got an illness: it doesn't just suddenly get better the minute lockdown's lifted.

Eating disorders are severe, potentially fatal illnesses. They have the ability to disrupt normal adolescent development and need swift identification and treatment to prevent damage and reduce the likelihood of a longer course of illness. Eating disorders include anorexia, bulimia, binge eating, excessive exercise and other extreme measures related to diet. Although they can affect anyone, they're most common among adolescent girls and young women, who are more likely to be preoccupied with their physical appearance and susceptible to social pressure to be thin. People with eating disorders can suffer from damage to the heart, brain, kidneys, liver, digestive and endocrine systems, skin and other organs. The fatality rate among anorexics is about 10%, making it one of the most deadly mental illnesses (Cotugno & Sapuppo, 2019). People with eating disorders are also at higher risk for suicide (Preti et al., 2010).

According to a CDC report released in March 2021, in the U.S. during the pandemic incidences of general anxiety, depressive, and adjustment disorders -- all risk factors for an eating disorder -- each rose between 80% to 90%. Eating disorders also became more prevalent, shifting from the sixth to the fifth most frequent disorder among those affecting teens (D'Ambrosio, 2021). Overall trends were similar for adolescents ages 19 to 22, but were less pronounced than for 13- to 18-year-olds (Canadian Consensus Panel, 2020).

All health care providers need to join in this fight against eating disorders. Especially during these stressful times, we encourage GPs and pediatricians to screen all patients who have lost weight for an eating disorder, even if their weight is considered to be in the "normal" range. Eating disorders occur in individuals of all genders, all ethnicities and all body sizes, making it crucial for providers to look beyond old stereotypes of who has an eating disorder. Many youths with an eating disorder will not express significant body dissatisfaction, but they may talk about wanting to be "healthy," losing weight the "right way" and express fear of becoming fat. Importantly, they may engage in behavior to avoid weight gain, even after being told that is necessary for their health (Courtney, 2020).

In the view of the above we can summarize the factors which this pandemic may exacerbate the risk of developing eating disorders in three main pathways (Rodgers et al., 2020). One, the disruptions to daily routines and constraints to outdoor activities may increase weight and shape

concerns, and negatively impact eating, exercise, and sleeping patterns, which may in turn increase eating disorders risk and symptoms. Relatedly, the pandemic and accompanying social restrictions may deprive individuals of social support and adaptive coping strategies, thereby potentially elevating eating disorders risk and symptoms by removing protective factors. Two, increased exposure to eating disorders-specific or anxiety provoking media, as well as increased reliance on video conferencing, may increase eating disorders risk and symptoms. Three, elevated rates of stress and negative affect due to the pandemic and social isolation may also contribute to increasing risk.

According to recent studies, we may finally assume that the pathogenic mechanism of social isolation in the development of eating disorders in early adolescence may rely on the immaturity of specific brain areas, In adulthood these brain areas modulate the non-specific neural response of midbrain areas to different stress stimuli. These studies have underlined the overlapping in neural response after social isolation and after fasting (Tomova et al., 2019; 2020). After isolation people felt lonely and craved social interaction: specific midbrain areas (substantia nigra and ventral tegmental area) show increased activation to social cues after isolation and to food cues after fasting: neural patterns in response to food cues when participants were hungry generalized to social cues after isolation. This midbrain neurophysiological overlapping between food and social craving is modulated by upper brain areas (prefrontal cortex and hippocampus), whose maturation process continue to be refined and stabilized during adolescence, in which executive functions reach adult levels of maturation (Murty et al., 2016). Social networking is the main reward that drives this psychological and neurodevelopmental process. As the recent researches in social neurosciences suggest, the dramatic increase of eating disorders in early adolescence, observed during the Covid-19 pandemic, may also be related to the incomplete development and integration of specific upper brain regions (hippocampus and prefrontal cortex), which modulate and differentiate the midbrain neural responses to hunger and to acute social isolation, the last one being the major characteristic of our life in the time of Covid-19 uncertainty.

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RESEARCH AND EMDR: NEW PERSPECTIVES

REPORT ON THE 10TH METZ ACADEMIC MEETING, METZ, FRANCE, *10–11 SEPTEMBER, 2021*

By: Juliette Machado, Berfin Bozkurt-Bayhan, Alix Lavandier, Jenny Ann Rydberg.

"EMDR is one of the psychotherapies that not only treat but also heal. Francine Shapiro passed away leaving us a gift for humanity. It is now up to us to be worthy of it." This is how Prof. Cyril Tarquinio set the scene at the 10th Metz Academic Meeting (MAM) in Metz, France, at which clinicians, doctoral students, and scholars meet to share and confront their thinking about EMDR therapy practice and research.

Research has demonstrated the effectiveness of EMDR therapy in the treatment of posttraumatic stress disorder in a wide range of contexts and populations. Case studies and series, clinical reports, and a number of comparative research studies have described how EMDR therapy may be implemented successfully in the treatment of several other forms of psychopathology and mental health issues. Yet, many questions remain following Francine Shapiro's passing. What do we know about EMDR therapy today, how does it work, how and when should it be applied, and to whom,

and what is its future? For two days, clinicians, doctoral students, and researchers proposed their humble and partial answers to these questions. Twelve presentations were structured around three axes of reflection that were constantly intertwined: a Clinical axis, a Neurological axis, and an Epistemological axis.

CLINICAL AXIS

The MAM is above all a seminar composed of clinicians. What could be more natural, than to give the floor first and foremost to clinical practice in the field, just as EMDR therapy emerged from a clinical experience? The MAM invites us to open the doors of institutions and private practices to meet psychotherapists at the core of their practice. This is an opportunity to hear the expertise of different consultants as well as the innovations of some psychotherapists.

Eva Zimmermann, from Switzerland, reminded us that the desensitization phase of the standard EMDR protocol (phase 4) presents several clinical choice points to the therapist. It appears to be a relatively simple phase for the therapist who stays out of the way to accompany the desensitisation and reprocessing process. Despite this stance, the therapist must nevertheless remain active and present while the patient goes through different stages, which are more or less emotionally intense. By maintaining this course and by their clinical choices, the clinician facilitates change, by continuously adjusting to the complexity of the emerging material, to the affective intensity, or to the issues that are specific to this phase of the treatment: dissociative phenomena, jumps between different traumatic targets, or even looping that requires cognitive interweaves (statements or questions aimed at eliciting adaptive information that may then link with the dysfunctionally stored, trauma-related memories). Changes in the client may manifest through the client's insights, a distancing of the negative material, a reprocessing at the emotional or sensory level, or more subtly at the imaginary level or even without externally visible signs.

Olivier Piedfort-Marin, also from Switzerland, argued that the theory of structural dissociation of the personality (TSDP) (Van der Hart, Nijenhuis, & Steele, 2006) may shed light on the processes at stake in EMDR therapy. TSDP is sometimes the object of a simplified and reductive understanding, summarised in the concepts of the Apparently Normal Part of the personality (ANP) and the Emotional Part of the personality (EP), to the detriment of an understanding of the mechanisms at play in trauma-related dissociation. Piedfort-Marin reminded the audience of the following: Contrary to the phenomenon of dissociation, the objective of psychotherapeutic treatment is the synthesis of the patient's lived experience, both in its different components (central synthesis) and over time (extended synthesis). Synthesis cannot be achieved without the realisation of the experience, which is itself distinguished in two stages: personification and presentification. Personification is the ability of the individual to feel that they have lived through a (traumatising) event, to take personal ownership of the lived experience. Presentification is the ability of an individual to integrate that the (traumatising) event has taken place in the past and is over, that they can act fully in the present moment and project themselves in the future. Piedfort-Marin proposed a new understanding of EMDR therapy's Adaptive Information Processing (AIP) model in the light of TSDP. In phase 4 in particular, the client's associations during the different sets of bilateral stimulation (BLS), involving emotions, cognitions, sensations, and behaviours, enable a central synthesis. The three-pronged focus (past, present, future) subsequently promotes an extended synthesis. Using clinical vignettes, Piedfort-Marin suggested that the therapist's interventions, such as cognitive interweaves, follow the same process of synthesis, first suggesting personification and then presentification, depending on where the client is at. As Eva Zimmermann had already illustrated, the role of the therapist in phase 4, which appears so "simple and minimalist, even withdrawn", then appears essential.

Clinical discussions were pursued regarding

applications in specific clinical contexts. Cyril Tarquinio, from France, shed light on the application of EMDR therapy in oncology. Cancer involves the conceptualisation of a specific psychopathology, it implies more than the cumulation of reactive symptoms or disorders. Recent work shows associations between depressive mood and adverse childhood events (ACEs) and the evolution of cancer. Furthermore, cancer is a word synonymous with "death" in the collective imagination. It is a succession of emotional shocks (diagnosis, treatment, relapse, upheavals in daily life and in the lives of loved ones, etc.) which not only generates psychotraumatological symptoms, but also feelings of vulnerability, despair, loss of control and autonomy. Life as a whole is then reshuffled, the cards are redistributed and priorities redefined. Because it is an illness that is rarely defined in time, it upsets the client on at least three levels in terms of temporality, identity, and changes in values. EMDR therapy appears relevant in the approach it proposes: it not only reduces reactive symptoms (depressive, anxious, post-traumatic) but can repair fractures in terms of identity and temporality. The EMDR therapist can thus work on optimistic projections, remobilise the individual in their daily life and give hope of a way out of the unbearable powerlessness imposed by cancer. Moreover, the idea is to help the client grow from this ordeal (post-traumatic growth), which allows them to access a new understanding of their world and of themselves, in an ultimately spiritual and deeply resilient dynamic.

For her part, Dolores Mosquera, from Spain, described the application of EMDR therapy to the treatment of women who have experienced domestic violence. Domestic violence causes many upheavals, not only because of the disturbing emotions that are experienced, but also and in particular, because of the internalisation of inappropriate response models. In other words, the domestic violence survivor then more or less consciously repeats a dysfunctional behaviour that has been learned. To this may be added certain cultural beliefs that are unfortunately still very much in vogue ("It is better for children to grow up in a family with a father and a mother, even if 'things happen' sometimes" or "If a man controls you, it is because he loves you"). The consequences for the woman experiencing domestic violence are numerous, among them: blocking of emotions (fear, shame, guilt, and sorrow for the partner), ambivalence or difficulties to protect oneself and to set boundaries. These emotional blocks lead to inappropriate responses that need to be identified in therapy. Identifying these difficulties in the client allows the therapist to define strategies for client's stabilisation, the extent of her resources, but above all to assess whether sufficient adaptive information is available. When there are many distortions, the processing of the trauma often remains blocked (due to the impossibility of connecting to adaptive information that is missing). As these clients have difficulties in feeling safe and ensuring their own safety, a strong therapeutic alliance will be absolutely necessary. The EMDR treatment plan will also depend on the client's degree of awareness, which is a key element of the treatment, and whether she is ready to leave her partner, something that is eminently difficult due to the ambivalence and idealisation of women towards their partners.

Mosquera suggested the following steps:

1. Explore the risk factors and try to increase the client's safety and protection as much as possible. Develop her social network and the ability to access it.

2. If the victim has to make important decisions, help her to assess the pros and cons of the situation, including the level of risk posed by each decision.

3. Assess responsiveness to problems, conflicts, and unexpected events. Address as necessary.
4. General psycho-education on gender-based violence.

5. Psycho-education on the difficulties presented by the client, including the link between her life history and the maladaptive learning of her current violent situation.

6. Self-care, improved functioning in daily life for the client and her children, if applicable.

7. Work on boundaries (emotional, physical, and psychological).

8. Work on emotions and defences (including self-regulation, to avoid relapses caused by emotional dependency and idealisation).

9. Work on trauma.

Mosquera then proposed to organise to target memories in a chronological order, or if they are too numerous and similar (as is often the case), to work on them in clusters as follows:

1. Memories of situations of immediate risk for the woman and her loved ones;

2. Targets related to memories of powerlessness, physical violence, and abuse;

3. Intrusive thoughts, cognitions or memories;

4. Negative early childhood experiences related to the problem presented in each case.

In order to circumvent the ambivalence and idealisation that clients may present and which impede the successful application of the standard EMDR, Mosquera suggested that specific interventions be executed first by desensitising the experienced positive affects that are dysfunctionally stored, similarly to what may be done in addiction therapy. After that, realisation is possible and classical EMDR treatment may prove effective.

If the MAM is a French and predominantly francophone seminar (although, this year, three of the twelve presentations were made in English), it also invites us to look at the practice of therapists around the world. Let's cross the Mediterranean and go to Turkey. Berfin Bozkurt-Bayhan presented the volunteer work performed within the scope of EMDR-HAP (Humanitarian Assistance Programme) after the biggest mining disaster in Turkey, in which 301 miners lost their lives in 2014. She introduced the EMDR Group Protocol (EMDR-GP) that was applied to children who lost their fathers and to mothers who lost their husbands (Korkmazlar, et al., 2020; Bozkurt-Bayhan, et al., 2022). EMDR-GP, administered 18 months after the disaster, is a group protocol which can be applied to participants aged older than 6 years and includes 8 phases of the standard EMDR protocol. One of the details that makes this voluntary study interesting is that the field study was not carried out for research purposes at first, but it was carried out on a volunteer basis. Therefore, a research design was created after the group intervention. It can be said that the strength of this study was the case presentation and the evaluation of the drawings of safe place, desensitization phase, and resource installation. According to the results of this voluntary study, it was shown that SUD (Subjective Units of Disturbance) levels decreased significantly during the intervention, and trauma-focused scale scores decreased significantly one year after the intervention for both children and mothers. It can be said that working with trauma is a difficult process, especially when working in the field. In the presentation, Bozkurt-Bayhan touched on the subtleties of intervening in the trauma field. The importance of exchanging information with a local professional, preparing a manual that allows for a structured intervention program before going into the field, and going to the field as a team within the framework of an association or institution was emphasized. In addition, attention was drawn to the evaluation of the emotional state of the therapists, the planning of individual EMDR sessions if necessary, and the organisation of daily consultations during the field study. As working in the trauma field is a challenging process, it was recommended that the working time in the field be 4-5 days. Finally, it was emphasized that it was important to present a report to the next team when finally leaving the field.

Opening up to the world is also an opportunity for clinicians to be inspired by other practices and to to share their experience with others. This is the case of Joanic Masson, from France, who presented how he combines EMDR psychotherapy with acupressure from Traditional Chinese Medicine (TCM), a medicine practice that is over 5000 years

old. Rather than performing SBL in the traditional way, Masson stimulates different acupressure points chosen according to the disorders presented by the patient. For example, point 40 Stomach (Feng Long), which is located on the outside of the thigh, can be used to facilitate the regulation of sadness and the release of the throat, in accordance with Chinese nomenclature, which maps the body not only by organs and bones as does Western medicine, but to which it adds, among other things, the meridians, which are the privileged channels through which energy (Qi) flows. Each meridian is associated with pairs of organs that have energetic, emotional, psychological, physiological functions, etc. However, Masson's presentation went further than the presentation of a clinical practice. He proposed to compare the EMDR psychotherapy model as we conceptualise it today with the TCM model. Firstly, because EMDR considers the need to integrate all aspects of experience in treatment, since emotions cannot be dissociated from the body, which is a fundamental postulate of TCM. Secondly, because the EMDR therapist in phase 4 is in a state that can be called "focused mindfulness" where they observe by being fully present to and mindful of the client (as brilliantly explained by Eva Zimmermann and Olivier Piedfort-Marin) and to themselves, and let the process happen. This implies that the process is self-organised spontaneously, perhaps sometimes unconsciously, in a way that is similar to that found in a hypnotic state - in short something akin to letting go. This "letting go" is in fact another fundamental concept of TCM, taken from Taoism: non-action (Wu Wei). In a few words, non-action is in no way inaction, but rather the ability to detach oneself from doing, from control, in order to let go. Paradoxically, it is thus an eminently active posture, but one that allows the body to do what it needs to do to regain its balance.

This understanding by Joanic Masson allows us a beautiful transition. The challenge for EMDR today is not only to evolve in its clinical practice, but also in a new epistemological perspective.

EPISTEMOLOGICAL AXIS

By definition, epistemology is the study of scientific knowledge. EMDR is today a true epistemological object, because it has been a revolution in the field of psychotherapy and psychopathology. This is the context in which Cyril Tarquinio set the MAM's first presentation of MAM, in which he addressed the clinical, theoretical, and moral considerations since the death of Francine Shapiro. EMDR therapy today is no longer limited to PTSD, it raises many questions about what psychotherapy is and how to understand the processes involved. Firstly, because EMDR is still poorly understood. It is mainly explained through the AIP model, which is more of a working hypothesis for the clinician, although very relevant and useful, rather than a scientifically valid model. The only other models that allow us to understand the processes at play are in neurology, which is both necessary and regrettable, because they limit the exercise of therapy to the use of bilateral stimulations or the exact application of the standard EMDR protocol, which seems to be far removed from the complexities of clinical practice. We lack a psychological theory. At present, only the theory of structural dissociation of the personality, as proposed by Piedfort-Marin in his presentation, could address this lack. Today, we should no longer think of science as being off the ground with rigorous methodological designs that are too refined and far from the complexity of clinical realities. Science without conscience is but the ruin of the soul, said Rabelais. The challenge today is to grasp all the numerous parameters that intervene in parallel and are in perpetual motion, and that we still have difficulty identifying in order to truly grasp what is at stake during EMDR practice.

It is in this perspective that a research project, presented by Juliette Machado, from France, was born in the hope of being part of this dynamic, the DETECT-EMDR project ("The therapist's dimension in the effectiveness of EMDR treatment of simple trauma: the forgotten dimension?") It was a question of starting from this epistemological postulate but also from a clinical observation, that few therapists strictly apply the standard EMDR protocol in their daily practice. However, it is clear that they obtain results, even though academic research shows that it is the strict application that

is the key! It follows that we might as well seize this paradox. The challenge was to consider the practice of EMDR as a professional situation and to study it as such, with methodologies borrowed from study of clinical practice. Indeed, it is well known in the field of professional psychology that workers never limit themselves to their job description, they take more or less freedom to be as close as possible to what they need to do. The same applies to therapists who adjust and adapt to the complexity of their clients, which can lead them to stray far from the guidelines set out by Francine Shapiro. By filming all the sessions, these two conditions were compared: a group of therapists who were asked to treat their patients strictly according to the standard protocol (strict group), and another group whose only instruction was to treat their patients "as they usually do" (free group). Among the different analyses carried out, let us retain the most original one: subjecting the therapist to the self-confrontation device, a device borrowed from the observational analysis of work activity. The therapist is invited to watch the video of their practice and comment on what they see themselves doing. Accompanied by the researcher, the aim is to make the therapist's practice more aware in order to approach what we call the "difficult to say" ("at that moment I made this choice for my patient, but I don't know why I did it, I sensed it that way"). Preliminary results were presented and already point to interesting observations: all therapists globally apply the protocol, including those who are free not to do so, although the latter have a more flexible practice, especially for phase 3. However, the protocol is always present as a red wire and the global steps are respected. It is in the application within the phases that differences are observed. Moreover, the way in which the protocol is experienced seems to differ from one group to another. The emotional commitment of the therapist is different according to the place they give to the technique in their work, but this observation seems to depend on the confidence that the therapist has in themselves, but also on the psychopathological complexity of the client and the type of target to treat. However, the protocol is very clear, and for both groups, how it interferes with the therapeutic relationship. The more the therapist describes themselves as close to their technique, the less they feel connected to their client, and vice versa. More detailed analyses are needed, but these observations invite us to open up the field of research in a different way and to grasp certain dimensions that are sometimes put aside. For example, it is the sensory that takes precedence when approaching this "difficult to say". Therapists feel a connection, without being able to explain why. The implications for research but also for the training of future therapists are promising. Where it will be possible to map, as far as possible, the therapist's representational universe as a key element in the effectiveness of EMDR.

Jenny Ann Rydberg, from France, pursued this epistemological questioning when describing the course of her doctoral thesis, which asks: “What would EMDR therapy be without its jargon?” Rydberg illustrated the evolution of a doctoral candidate’s thinking while working on their thesis, from initial hypotheses to ever-changing nuances built on the evolution both of one’s own thinking and relevant publications in the field (scientific publishing is not put on hold to give us the time and opportunity to demonstrate and publish our original ideas!). The presentation addressed the question of EMDR therapy’s status as an integrative psychotherapy as well as the relevance of the ever-increasing number of EMDR special protocols, claiming to address the specific needs of different populations, outcome goals, and contexts. Rydberg then moved on to the most recent relevant developments in the field that attempt to address the issue of the future of EMDR therapy, including presentations by Michael Hase and Peter Liebermann at the EMDR Europe conference in June 2021, and the November 2021 article by the Council of Scholars’ (Future of EMDR Therapy Project) “What is EMDR?” article published in the Journal of EMDR Practice and Research. These most recent developments seem to show that EMDR therapy is destined to be regarded as an integrative psychotherapy approach; formulated in a manner based on terminological, conceptual, theoretical, and epistemological clarifications; situated within

a broad field of psychotherapies with common ancestors; where EMDR therapy consists of the characteristic and idiosyncratic assembly of certain elements common to several psychotherapies, with guidelines for adaptations under the form of standard variations. It remains for the field to define the boundaries of what constitutes EMDR, perhaps in the form of concentric circles.

In another register, but one that has proved to be more topical than ever, Alix Lavandier, also from France, continued this epistemological reasoning by addressing EMDR therapy in an integrative protocol, the TIM-E protocol, using virtual reality in particular. In the Cronos CPTSD project (the TIM-E protocol: Understanding and functioning of a new integrative protocol for adults suffering from Complex Post Traumatic Stress Disorder), the idea is to start from a clinical observation, the difficulty of dealing with CPTSD, and to propose to understand the functioning of the TIM-E protocol, which has provided encouraging initial results on the symptoms of this disorder. The TIM-E protocol (Temporalist Investigation Model & Experiencing, Dieu and ARCA, 2016) proposes that people focus on temporality by using time as the main variable. The TIM-E model is inspired by and uses different already-existing models and concepts: the temporal perspective (Zimbardo, 1999), AIP, the social learning model (Bandura, 1980) and the Good Life Model (Ward, 2002). The TIM-E protocol is divided into 9 individual sessions (with virtual reality with a temporal perspective, cognitive distancing exercises, exercises on basic needs), 9 group sessions (development of interpersonal skills, construction of temporal identity, cognitive distancing, work on erroneous cognitions) and EMDR sessions.

The methodology of this doctoral research was designed in relation to other research already underway on EMDR therapy and should provide data, particularly on the temporal perspective, the therapeutic alliance, and psychological flexibility in the management of CPTSD using EMDR. The aim is to come as close as possible to what is done in current care practice. The interest of this research is therefore both clinical and scientific: Clinicians are therefore confronted with many difficulties in the treatment of CPTSD and research does not always reflect this clinical complexity. This work is intended to test the effect of the TIM- E protocol and also to understand how it works.

NEUROLOGICAL AXIS

Finally, let us finish this overview of the 10th MAM by taking a step back into clinical practice and allowing scholars to meet clinicians. Ad de Jongh, from the Netherlands, took us on a journey between past, present and future. After a brief history of EMDR therapy, he questioned EMDR therapy on several points, in particular: how does EMDR work? How can eye movements allow the emotional discharge of negatively encoded memories? He reminded participants of the teachings of Francine Shapiro. By targeting the memory of the event (thoughts, sounds, images, sensations, emotions, beliefs, in short, everything that was encoded at the time of the event) and by stimulating "the information processing system", this memory transmutes along the processing system into an adapted memory network. As a result, this memory and the components of the memory change.

Research seems to show that performing eye movements, while keeping the targeted memory in mind, works best to degrade the memory in question. The speed of the eye movements is of great importance. The more and faster the movements, the better for the client, but the movements do not have to be horizontal. According to De Jongh, this is a myth in EMDR therapy. Vertical movements would work better, he claimed. Shapiro, by the way, initially mentioned diagonal movements. In the studies presented by De Jongh, there is no difference in effect between horizontal or vertical eye movements. It would follow that it is not so much the bilaterality that is important for the degradation of the traumatic memory, but the fact that the targeted memory is kept in mind and sufficiently activated during the process, otherwise the eye movements would be useless. De Jongh also strongly emphasised that eye movements are not the only effective task. Horizontal or vertical eye movements work, but auditory or drawing tasks

also help to reduce the emotional load and thus the complete processing of disturbing memories. Eye movements and all dual attention tasks produce comparable effects. According to De Jongh, all these studies indicate that it is better to use the term "lateral eye movements" and not "bilateral stimulation". Thus, it is the working memory hypothesis that he favours as the operating model of EMDR. The evocation of a memory brings the memory back into short-term memory, and if a second task is requested during this recall, the emotional charge of the memory will diminish and it can then be reconsolidated in long-term memory in a different way.

We must add that the working memory model does not explain everything that is observed in EMDR therapy and that other mechanisms probably also play a role. However, the working memory theory helps to understand why EMDR may not always work, for example where the emotional charge of the memory is too low or the simultaneous task is not sufficient.

After Tarquinio's presentation on the application of EMDR therapy to cancer patients, Sarah Carletto, from Italy, presented clinical and neurobiological evidence of EMDR therapy in cancer patients. In the first part, she discussed the studies on the relationship between cancer and psychological distress. She drew attention to the fact that depression and anxiety are better known in the relationship between psychological distress and cancer, but that there are few studies on psychological interventions for PTSD in medical patients. According to the results of studies conducted with cancer patients, EMDR can be a potentially effective treatment for psychological distress in cancer patients. In the second part of the presentation, Carletto included neurobiological studies showing that the same brain structures play a role in non-oncologic PTSD and psycho-oncologic cases (in particular intrusive symptoms) (Carletto & Pagani, 2016). In the latest study by Carletto et al. (2019), it was shown that there was a significant decrease in depression and PTSD symptoms in cancer patients receiving EMDR therapy. Another important result is that activation was observed in the left angular gyrus and right fusiform gyrus regions in patients who had EMDR therapy when compared with the treatment-as-usual (TAU) according to the EEG results. Therefore, activation of these regions with EMDR therapy facilitates the contextualisation and reprocessing of the traumatic event by providing the activation from the limbic regions involved in emotional states to the cortical regions. All these studies raise new research questions about psychological distress in cancer patients. Finally, the difficulty of identifying the single traumatic stressor, the fact that the situation is an ongoing stressor, intrusive symptoms are future oriented, and the re-experiencing criterion that is associated with the risk of recurrence of the symptoms are important factors for the enrichment of clinical studies on cancer.

ONCLUSION

"Documenting your outcomes and sharing it is 'research.' Research is not just about proving to others. It is a way to guide each one of us to establish the best practices. It is about staying on the right road". Shapiro.

The MAM hopes to contribute to this research, dynamic, engaging in discussions and bringing together neurology, epistemology and clinical practice. We look forward to seeing you in 2022 for MAM#11!

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Photo: Romain Kraft

NEWS FROM THE UK

By: Valerie Sinason

The small professional world of colleagues working with extreme and ritualistic abuse in the UK has just been rocked by news that a leading pioneer in this field, Wilfred Wong, a thoughtful and compassionate human rights barrister, had been arrested. Wilfred Wong, aged 56, had apparently kidnapped a child at knife point from their hysterical foster-mother and had slashed the foster-mother's tyres so she could not follow. Together with five others, he went off in a getaway car, had lookouts on bridges from Anglesey to the mainland and was finally stopped on the M1 motorway in Northumberland by police. The Crown Prosecution Service said "The facts of the case are chilling, and it must have been a terrifying experience for the child and carer."

At a time of such disinformation and fake news how do we trust or process what we read? How do we trust or process our own supposed knowledge of a

person? A respected thoughtful barrister abducting a child at knifepoint - was that possible? Was it planted? The news was shocking in itself. In addition, it was shocking that this major item of national news - a barrister, a counsellor and other respected professionals kidnapping a child - was only reported in a small Welsh newspaper and not immediately picked up in the significant way you would expect in the quality or tabloid major press. Moreover, given the gagging orders placed on reporting, whilst we know the accusation and harsh final sentencing we do not know the information which led to these actions. This raises concerns about fairness.

Wilfred Wong has worked with the unpopular and unpalatable subject of ritual abuse, especially Satanist abuse, for over 3 decades. He had been despairing of the failure of many investigations and worked hard to raise parliamentary awareness. He was also very aware of the problems caused to mothers who accepted their children's disclosures of such abuse only to be "othered" as having "mental health problems" if they believed their child. The worrying result, which we have seen in the UK through groups such as LASA, was often the child being returned to the allegedly abusing parent and the mother being denied contact. Knowing miscarriages of justice combined with the secrecy of family courts and lengthy gagging orders there is reason to have concerns about justice.

Could this be such a case? Did the important need to protect a child's identity cause unfairness or injustice in other aspects of this case? Did the Judge have no alternative? Had Wilfred Wong totally given up on legal structures? Did he have a breakdown? Why would he bring or use a knife? Was it planted? There was no safe way of finding out the answers to any of these questions.

The internet is filled with illegal data which might or might not be true. Repeating it would be illegal.
The initial amount of media coverage accused him of being in a "gang" of six who had "plotted" this "chilling abduction" in a way the Judge described as having " caused unspeakable misery and considerable harm." This reporting did not mention his impeccable human rights record. However, without explanation, further newspaper reports followed, quietly changing the word "gang" to "group", creating a very different linguistic atmosphere.

Additionally, with another piece of reporting restriction removed, it was stated that a man had kidnapped a child to save said child from Satanist abuse but to protect the confidentiality of the child there were reporting restrictions over the identities of family members. Clearly, child abduction and kidnap carried out by a gang with a knife is very different to an attempt to "save" a child at the request of people possibly close to the child.

However, outside of illegal information on the internet, we do not know. By the end of August, British readers were told that all had been found guilty except for one woman. One of the accused was found dead on remand and it is still not known if that was suicide. Given the lack of reporting we cannot establish anything in a fair way.

The final shock came on 30th Sept 2021 when BBC News and other media announced Anke Hill and Wilfred Wong snatched the child from their foster carer as they arrived home from school. Hill put the child in a waiting car, while Wong held a knife to the foster carer's throat before slashing one of the carer's car tyres to prevent them from following.

Hill was jailed for 14 years and five months while Wong was given a 17-year jail sentence. Wong was told by the judge "you still have a clear under-lying belief in these accusations".He was given a concurrent sentence of two years and six months for possession of a bladed weapon. Janet Stevenson was jailed for 15 years and was told she still had "entrenched views on the victims of satanic ritual abuse" and, like Hill and Wong, there was a danger she would reoffend in the future because of her belief that children were victims of satanic ritual abuse. Her husband, Edward Stevenson, who had helped in the conspiracy by hiring a car to drive the child away from Wales was jailed for eight years for his "essential" role. Two others, from Holyhead, acted as lookouts on bridges from Anglesey to the mainland to spot any police activity.

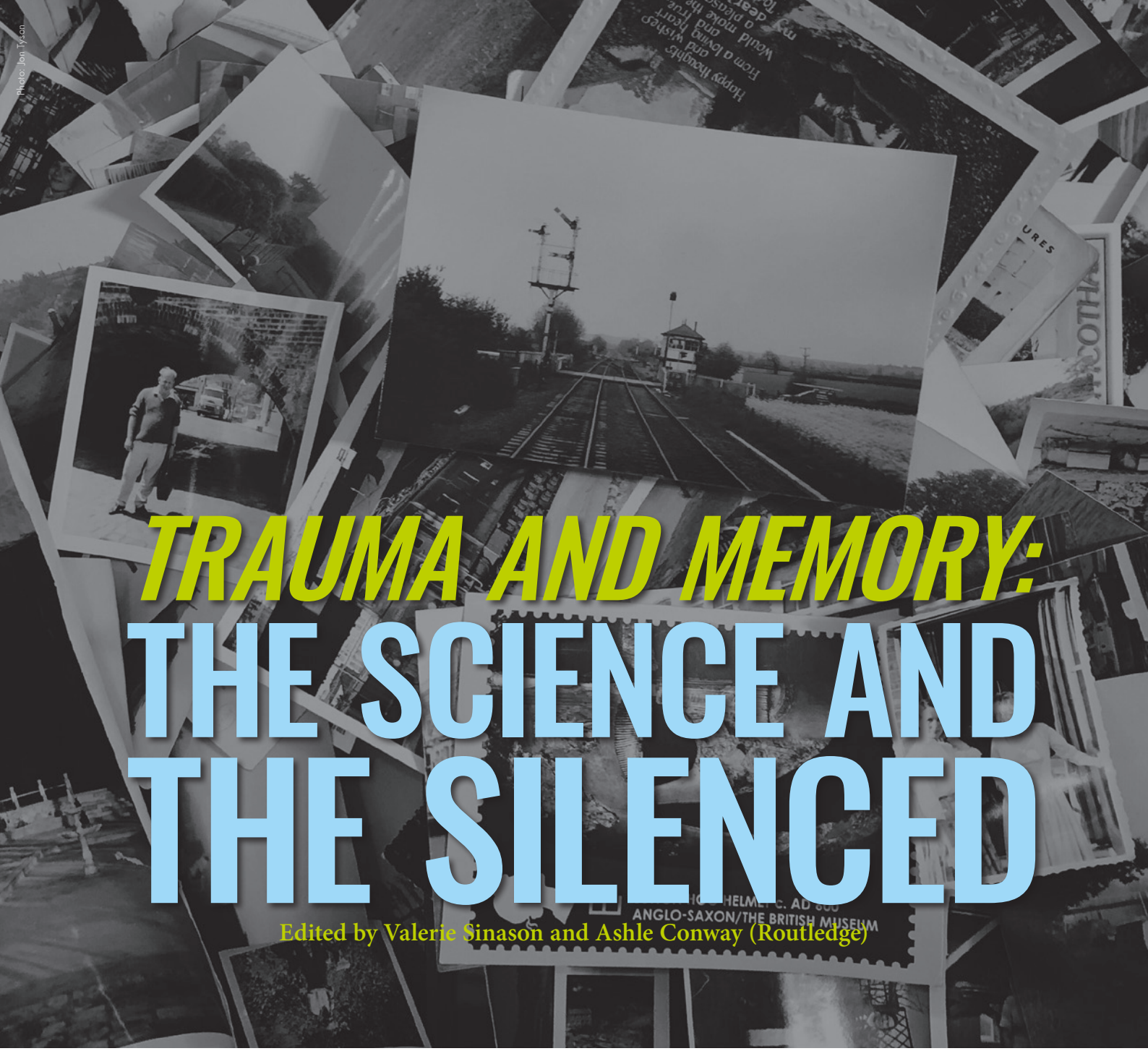
Going-Hill was jailed for four years and eight months, and Petley for four years. The judge said the pair had carried out surveillance prior to the kidnapping.

Wildred Wong has received a sentence longer than murder. This is similar to the infamous case of "Nick", Carl Beech, a man given a similar prison sentence for "lying" he had been abused by famous people. Where a sentence is longer than rape and murder something disturbing is usually being enacted.

Whilst international convictions for Satanist abuse are widely published (Sinason 1992), it appears the Judge has treated such knowledge as if it was a terrorist fundamentalist system rather than a fact. Without evidence we cannot say what the facts were in this case. But the Judge's comments were left to be published whilst the words of the accused are not. This does not bring confidence.

A fine man is facing a prison sentence of an extraordinarily length and we are not told why. Those of us who have seen abused children terrified of getting into trouble by naming a parent cannot rest satisfied by the idea that this poor non-identified child is now "safe" with a parent. How do we know? We don't. This could be a huge miscarriage of justice or it could be correct.

What we do know in our tragic and difficult area of work is that fine people get worn down by the tragedy of what they are hearing and try to act, to save rather than bear the slowness of changing the structures of family courts and evidence. Robert Green, a fine advocate for a young woman with Down's syndrome, Holly Greig, who accused a high level Scottish official of abuse. died of a heart attack after facing imprisonment and being gagged, unable to speak about her case. We are too small a group to afford such tragic losses. Going to prison does not aid this work. It adds to the trauma being carried. Let us all keep an eye out to ensure as much justice as possible is available to colleagues who step too far in their longing to help, as well as nurturing our own personal resources. Staying within the law matters and so does showing where the law is unfair and needs to change.



TRAUMA AND MEMORY: THE SCIENCE AND THE SILENCED

Edited by Valerie Sinason and Ashle Conway (Routledge)

Review by Dehra Mitchell

As stated in the introduction, this book started life as a second edition to Memory in Dispute (Routledge, 1998). What now exists is a fascinating, if somewhat depressing, look at what has changed and what remains the same. Not everyone will agree or even like some of the chapters included in this book, but that is exactly why this book is so important. Whether you agree or disagree, you will think and hopefully question your own assumptions and truth.

We exist in a world where "truth" is subject to interpretation, where "fake news" is accepted as a rational for something we don't like. We seem to want to live in the nursery, where nothing ever goes wrong and evil only exists in fairy tales, where mummy and daddy are always kind and always right. In short, a dissociative state where reality only exists at arm's length, if at all. Michael Salter, in his chapter Finding a New Narrative, argues for "…the opportunity to tell a new, and more hopeful, story about abuse and trauma". (pg. 131)

Reality, memory, and trauma are explored in this examination of the far-reaching consequences of "living in the nursery." Some of the chapters are a sort of historical record of where we were, in terms of memory, and where we now find ourselves. (Marjory Orr, Ashley Conway, Susie Orbach, Brett Kahr and Ann Scott), whilst others explore the science and research into memory (Winja Buss, Mary Sue Moore). The media comes in for special attention/criticism. (Lynn Crook, Michael Salter)

While it is true that the media has shown a spotlight on abuse and abusers, they have also chased new shiny stories which stand in opposition to what has been previously reported. The founders of the False Memory Society (FMS) knew very well how to play a bored media to great effect utilising the flawed "Lost in the Mall" study. (Valerie Sinason) Although the Society has disbanded, the seeds of disbelief have been sown and continue to grow. The book is dedicated to Professor Jennifer Freyd for her "courage, dignity and her illuminating research lens…" (Dedication)

Included in the examination of history and science, is the very real effect working with trauma has on practitioners. We like to think of ourselves as somehow protected from the stories our patients recount, that our training, professionalism, and balance will guard us. Perhaps we sometimes forget that we are only human, that our very humanity puts us at risk. Some of us will continue – sometimes to the detriment of ourselves – and some will know when it is time for them to stop. (Jennifer Johns, Phil Mollon).

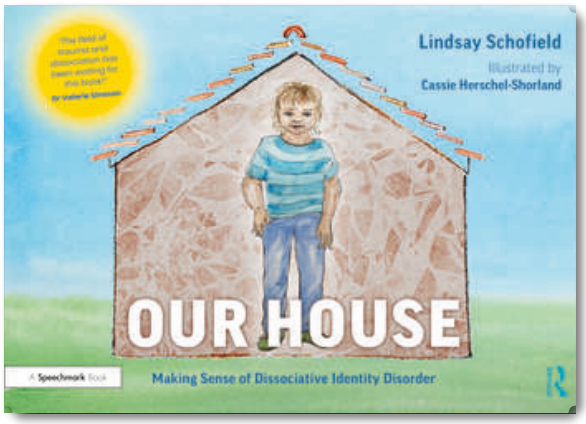
The final chapter "Do no harm"? explores structure, society, assumptions, ethics and the need for change (Khadija Rouf, Danny Taggart). It includes a proposed guideline for working with survivors and victims and invites thought and debate about how we embark on this very difficult work.

"Safe cultures depend on trust, a non-blaming attitude to unintended mistakes, shared values and a sense of individual responsibility." (pg. 151)

Book review by: Michele Leslie Jowett

Our House: Making Sense of Dissociative Identity Disorder Understanding Dissociative Identity Disorder: A Guidebook for Survivors and Practitioners

WRITTEN BY LINDSAY SCHOFIELD, ILLUSTRATED BY CASSIE HERSHEL-SHORLAND (ROUTLEDGE)



This book review explores two complementary and delightful books: the beautifully depicted 'Our House - Making Sense of Dissociative Identity Disorder' and its comprehensive companion guide 'Understanding Dissociative Identity Disorder: A Guidebook for Survivors and Practitioners'. Both are a welcome and timely contribution to the field of complex trauma, elucidating a disorder that is both a dependable, laudable and creative resource for survival in the face of overwhelming trauma, yet, bafflingly, continues to court controversy and unsubstantiated doubt regarding its authenticity. It is my firm belief that the author's work will illuminate the former and contribute significantly to quashing the latter. The books are for dedicated clinicians and the inspirational survivors that they treat in tandem with all those who love and support them. Both are written in a way that makes the complexities of Dissociative Identity Disorder easy to digest and assimilate, provoking thought and reflection whilst broadening one's understanding of the landscape of developmental trauma. The exquisite pictures in the picture book beautifully capture the internal world that is populated by parts whose ingenious creation enabled the outside part's survival. Likewise, they vividly illustrate the outside part's struggle to orient themself to this inner landscape and the challenges that such a complex process poses. The Guidebook's compelling and assimilative narrative complements the intricacies of the illustrations, both taking us on a journey that is inspiring, fascinating, educational and insightful. I am going to review both books separately before commenting on how they marry and knit together to create a unified whole.

As a reviewer, I am fortunate to have a broad panoramic view of these books given I can explore them through the lens of a survivor of complex trauma, a person living with the complexities of DID and as someone who has spent five years training to be a psychotherapist. Each provides a unique, dynamic perspective. It is also important to note that the books are not being reviewed just by me as the outside, highly functioning part but by my parts, equally whose ages are diverse thereby lending greater meaning and scope to this review. It is important, therefore, for the reader to be aware that this is a collaborative and collective response whilst written in my voice.

The picture book cleverly accommodates children and adult readers. The delightful and engaging

pictures punctuate a simple narrative that effortlessly lends meaning to them. It commences with an overview for adults, drawing on the metaphor of life being like a house and inviting the reader to imagine that everyone's house is the same at birth. However, just as a person's life is impacted by circumstances, so, too, is a person's house depending on the environment, location, acts of nature, the people who inhabit it, etc. Consequently, some houses will be warm, nurturing, and safe whilst others will be cold, harmful, and threatening. The child in the picture book, who is also the narrator, explains that her house was impacted by trauma. The author proceeds to explain what trauma is and how traumatic memories can be dissociated as a survival resource and a means of protection when the brain is unable to process and store them. Significantly, children below the age of seven can have the propensity to develop parts to manage the trauma for them enabling the outside part to perform daily duties and function normally. The trauma remains hidden until a similar experience triggers unanticipated recall or until it can no longer remain out of conscious awareness. Adopting the metaphor of the house, the child explains how a bad thing happened to her house resulting in a part of her splitting away. This part created another room where they hid and held the memory unbeknown to the child. As more bad things happened, more parts and rooms were created with parts returning to manage the bad things that kept being repeated thereby enabling the child to function in everyday life. When these bad things occurred, the child lost time, retreating to an imaginary place inside or experiencing unexplained gaps in her memory. This introductory page finishes on a note of gratitude as the child recognises the parts' courage, strength and helpfulness.

What follows is a striking and evocative picture representation of the adult's overview as described above, twinned with a simple but engaging narrative to complement its depiction. The pictures are remarkably real, expressive, intricate and sophisticated lending a gentle rawness to the book's creation that is unsurpassed. They communicate at a deep level, making conceptualisation of a challenging disorder easier to understand. The pictures and narrative communicate why and how parts of the child evolve, their diversity in age, gender and role, how some might be co-present and co-conscious, but some may not, how there can be conflict and disharmony, confusion and hostility, how help is needed to foster harmony and collaboration despite trust being fragile and splintered and how, ultimately, the system is working to 'be okay.'

The picture book closes with reference to the continuum of dissociative disorders, the function of dissociation as a defence against experiences that are too overwhelming for the mind to process and store and with special allusion to Dissociative Identity Disorder. It illuminates its symptomatology, the controversy it courts and the author's reflections on what feeds the perplexing and stubborn belief it is fabricated. Further reference is made to the phenomenon of poly fragmentation manifesting in a considerable number of parts and symptomatic of ritualised and organisational abuse. Other Specified Dissociative Disorder (OSDD) is also explored, recognised as the most prevalent dissociative disorder in the general population and with four subtypes that are identified and described. The reader is urged to seek professional help if their symptoms mirror those reflected in the picture book, highlighting that there are diagnostic assessments available whilst cautioning that not all symptoms are indicative of a dissociative disorder. The author ends on a poignant yet confronting note, cleverly using metaphor to elucidate dissociation and recovery of memory whilst, simultaneously, summarising all that the picture book deftly communicates. This impressionable and pertinent metaphor commands the reader's awe for the survival brain's considerable resourcefulness in the face of inconceivable adversity whilst garnering respect for survivors' courage and resilience when surviving society's most heinous of horrors.

Understanding Dissociative Identity Disorder: A Guidebook for Practitioners and Survivors is a companionable guide to the picture book. It is encyclopaedic in its vast delivery of information, beautifully and exquisitely crafted and an

imperative read for every clinician practising in the field as well as the courageous survivors that they treat. It richly honours people living with DID, recognising their courage, strength and resilience whilst celebrating their enduring and staggering survival. The poignant dedication on the book's opening page reflects these hard-earned sentiments and the gratitude, passion and respect behind the author's carefully chosen words are touchingly palpable. From start to finish, the author demonstrates sensitivity to readers who are survivors. For example, she punctuates the narrative with a broken 't' symbol as identified in the introduction to indicate that something might be triggering and offers techniques on how to manage triggers. Careful consideration is given to wording so that 'the language of partnership, equality and respect' is consistently upheld. The text communicates the author's caring and warmth, gentleness, and nurturance so that readers are contained as they navigate the tumultuous seas of trauma. The guidebook is relational, beautifully reflecting how integral the relationship is to healing. The introduction offers a pertinent overview of the subject highlighting that the purpose of the guidebook is to complement other available treatment guides and resources rather than compete with them. Chapter 1 identifies the different faces of trauma, makes interesting reference to the disparity between 'capital T traumas' and 'small t traumas' whilst cautioning the cumulative impact of the latter. It comments on the accumulative effect of Adverse Childhood Experiences (ACEs), highlighting their harmful and enduring manifestations. It describes how and who trauma impacts, its immediate and long-term imprint whilst illustrating the mind and body's remarkable malleability and capacity for healing and growth. Chapter 2 explores dissociation and its presentation, examines how trauma impacts the memory whilst explaining the continuum of dissociative disorders. It provides a brief outline of DID and how it might be experienced by the outside part and her parts. The chapter ends with a concise but factual and assimilative summarisation of DID. Chapter 3 examines treatment interventions whilst alluding to the tri-phasic model and how the therapeutic relationship is fundamental to healing. It endorses screening interventions for assessment and to safeguard against incorrect treatment whilst differentiating between trauma conditions, significantly PTSD, Complex PTSD and DID. Chapter 4 is dedicated to survivors and those who care for them. It explores trauma, dissociation and parts whilst addressing core elements to recovery. It offers practical guidance with respect to finding professional help, self-care for supporters and management and grounding techniques for flashbacks. Chapter 5 examines screening and assessment tools whilst offering an informal self-assessment that measures negative effects and behaviours in response to difficulties. It explores facets central to professional practice such as the imperativeness of supervision and supportive professional networks whilst advocating for self-care to protect against the perils of Compassion Fatigue: burnout and vicarious trauma. Chapter 6 offers a comprehensive list of learning resources for both practitioners and survivors in addition to some self-help suggestions. Lastly, chapter 7, the largest section of the guidebook, provides a broader, more in-depth and expansive perspective of the pictures and text pertaining to the picture book and examines how they might be explored in treatment in conjunction with the therapist or individual. It is rich in information and provides a vivid and elucidating panorama of DID's fascinating, colourful and intricate landscape. Its tone is relational and the author's respect and admiration for survivors weaves palpably throughout the text. The book ends on an empowering note as the author urges survivors to find a companion to journey with and to refuse to be defined by the trauma that was perpetrated on them and by the perpetrators themselves. Significantly, some material from the Guidebook can be photocopied and downloaded from Routledge for added convenience in the therapy room or outside of it.

To review a work of this magnitude is an honour and a challenge given the high esteem in which I hold it and my desire to communicate the breadth of its brilliance competently. To capture the essence of the author's literary achievement

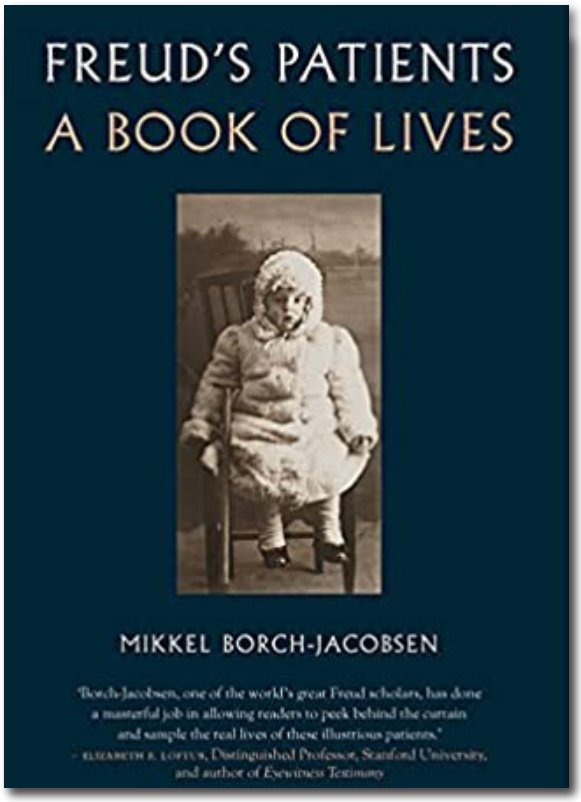
is to draw attention to its unique, compelling presentation that straddles both adult and child readership, its relational, containing style and its comprehensive expression of a subject that is vast and complex yet seamlessly renders it accessible and assimilative. Both books empower survivors, inform and reassure practitioners whilst gently supporting loved ones. The books are meteoric in their achievement, a timely and imperative gift to the field of complex trauma and worthy of prime space in every therapy room. The concept of a picture book and accompanying guidebook is novel in the treatment of DID providing a road map that is easy to navigate and a landscape that is well defined and refreshingly clear. For the survivor, there is safety in the pages, their sensitivities that are born from trauma being met with respect and caring, providing a reading experience that is contained and nurturing rather than fearful and anticipatory. The guidebook is rich in fact, rigorous in detail and meticulous in its exploration whilst the picture book is a visual delight, a rudimentary resource and a creative joy. Above all else, both books are testament to the resilience of the human spirit, the adaptability and genius of the human brain in response to trauma and the mind, body and spirit's capacity for healing, recovery and growth. They are a celebration of survivors' strength and courage in the face of humankind's heinousness and depravity whilst honouring the dedication and fortitude of the practitioners who care for them. They are a welcome addition to the field of complex trauma and a phenomenal achievement of the author and illustrator. The books are the amalgamation of two creative minds where writing and art are married to support each other in conceptualising a challenging and complex disorder with ease. It is without doubt that the author's wish that the books will 'dispel confusion and misinformation and inspire confidence that the legacy of trauma and dissociation need not extend into an unwritten future' has been deservedly and richly achieved. I applaud both author and illustrator for this phenomenal achievement and thank them for such a timely contribution to the field.

Book review by: Valerie Sinason

Freud's Patients A Book of Lives

MIKEL BORCH-JACOBSON

2921 ReAction books. 300 pages



Is a dead patient's entitlement to privacy any different to the confidentiality given to a living patient?

What about the confidentiality of the therapist or the therapeutic dyad when all parties are dead? If the patient is famous or the therapist is, does that alter confidentiality? After how long a period is historical research ethically useful?

These important ethical questions are evoked by the publication of this book by Mikel Borch-Jacobson, a significant historian of psychoanalysis and psychiatry who is famous for his criticisms of psychoanalysis and his wide-ranging interest in philosophy, history, history of psychoanalysis and comparative literature.

As well as the ethical questions around the nature of the book, there is a cover endorsement by Elizabeth Loftus, a well-known supporter of false memory narratives. This, together with the preface by the author, will evoke discomfort in many psychoanalysts or psychodynamically trained therapists and counsellors for its hint of a particular bias. The last sentence of the preface unequivocally states "Freud's cures were largely ineffectual, when they were not downright destructive"

The book consists of 38 small chapters, each providing a brief historical portrait. Those selected include Bertha Pappenheim, Martha Bernays, Emma Eckstein, and Anna Freud. Each chapter provides a useful vignette, often accompanied by an illustration. The chapters provide a valuable illustration of the social world in which Freud was embedded. Whilst there is useful historical information here, it comes with a complex shadow side. Neither patient nor analyst are free to interrogate the comments.

It is salutary to remember the historic time Freud lived in when he initially approved some of the barbaric operations that were accepted and approved in psychiatry (chapter 13, Emma Eckstein) before the talking cure fully took over. However, the aim of the book is not to show the revolution caused by talking and listening rather than operating. As well as providing useful historical background, the book seeks to demonstrate that not only were Freud's cases largely unsuccessful but that lesser-known pieces of his clinical work were damaging and, moreover, he used his wife as a case study.

Success of a treatment is not necessarily shown by gratitude. The fact that the author can show us comments from former patients and their friends and relatives that were negative about treatment does not provide any definitive answer. A historian cannot provide that. Similarly, hearing about therapeutic failure cannot help us understand whether the difficulties were intrinsic to the analytic dyad or would have occurred with anyone.

However, for those who want to peep behind the therapy door, understand historical connections or dent any unhealthy idealisation of everything a pioneer said and did, this offers a complex glimpse. A book co-written by Borch-Jacobson and a psychoanalytic historian such as Brett Kahr- now that would be really helpful!

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!

A Pilot RCT of a Body-Oriented Group Therapy for Complex Trauma Survivors: An Adaptation of Sensorimotor Psychotherapy

Classen, C. C., Hughes, L., Clark, C., Hill Mohammed, B., Woods, P., & Beckett, B.

This study is a pilot randomized controlled trial that examined the efficacy of a body-oriented group therapy designed to address chronic fear states in the body due to complex trauma. The Trauma and the Body Group (TBG) is a 20-session group psychotherapy that draws upon the principles and techniques of sensorimotor psychotherapy. Thirty-two women with a history of childhood trauma were randomized to immediate treatment or a waitlist control condition. Assessments were conducted one month prior to treatment, immediately after treatment, and six months post-treatment. Significant improvements were found in body awareness, anxiety, and soothing receptivity when comparing treatment to no treatment. The TBG appears to be a valuable tool for helping clients acquire mindfulness and self soothing skills that they can use to reduce posttraumatic symptoms. This study provides preliminary evidence that the TBG provides complex trauma survivors an opportunity to challenge their avoidance of two prominent trauma-related triggers – their bodies and interpersonal relationships – and in so doing may help survivors develop greater body awareness, increase their capacity for self and relational soothing, and reduce their anxiety symptoms.

Classen, C. C., Hughes, L., Clark, C., Hill Mohammed, B., Woods, P., & Beckett, B. (2021). A pilot RCT of a body-oriented group therapy for complex trauma survivors: an adaptation of sensorimotor psychotherapy. Journal of Trauma & Dissociation, 22(1), 52-68. [retrieved 19/12/2021]: https://www.tandfonline.com/doi/abs/10.1080/15299732.2020.1760173

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. (2021). Dissociative identity disorder: out of the shadows at last?. The British Journal of Psychiatry, 219(2), 413-414. [retrieved 19/12/2021]: https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/dissociative-identity-disorder-out-of-the-shadows-at-last/8E2884FA8669A9A64790E5C47AD72DC7

A Critical Analysis of Myths About Dissociative Identity Disorder

Dodier, O., Otgaar, H., & Lynn, S. J.

In a review of the literature in this journal, Piedfort-Marin et al. (1921) identified what they purported to be myths about dissociative identity disorder (DID) and dissociative amnesia. When responding to these beliefs, they supported the Trauma Model of dissociation and argued for a causal etiological link between trauma and dissociative conditions. In contrast, they challenged the Sociocognitive Model (SCM), which they claimed rejects the existence of DID and associated disorders (e.g., dissociative amnesia) and considers symptoms to be the byproduct of fantasy, suggestion, and the iatrogenic effect of psychotherapies. In this article, we critically evaluate the authors' arguments and propose a more balanced, accurate, and comprehensive view of the sociocognitive model. We demonstrate that this model neither rejects the existence of DID, nor a link between trauma and dissociation potentially mediated by a variety of cognitive-affective-behavioral variables. We argue, contrary to Piedfort-Marin et al., that the tendency to confabulate and other cognitive and sociocultural variables may also contribute to the development of DID. We contend that a multifactorial integrative etiological perspective can move the field beyond a limited focus on controversies that divide the TM and SCM models of dissociation.

Dodier, O., Otgaar, H., & Lynn, S. J. (2021, October). A Critical Analysis of Myths About Dissociative Identity Disorder. In Annales Médico-psychologiques, revue psychiatrique. Elsevier Masson. [retrieved 19/12/2021]: https://www.sciencedirect.com/science/article/abs/pii/S0003448721003395

Increased Proportion of Physical Child Abuse Injuries at a Level I Pediatric Trauma Center During the Covid-19 Pandemic

Kovler, M. L., Ziegfeld, S., Ryan, L. M., Goldstein, M. A., Gardner, R., Garcia, A. V., & Nasr, I. W.

Background and objectives: The Covid-19 pandemic has forced mass closures of childcare facilities and schools. While these measures are necessary to slow virus transmission, little is known regarding the secondary health consequences of social distancing. The purpose of this study is to assess the proportion of injuries secondary to physical child abuse (PCA) at a level I pediatric trauma center during the Covid-19 pandemic.
Methods: A retrospective review of patients at our center was conducted to identify injuries caused by PCA in the month following the statewide closure of childcare facilities in Maryland. The proportion of PCA patients treated during the Covid-19 era were compared to the corresponding period in the preceding two years by Fisher's exact test. Demographics, injury profiles, and outcomes were described for each period.
Results: Eight patients with PCA injuries were treated during the Covid-19 period (13 % of total trauma patients), compared to four in 2019 (4 %, $p < 0.05$) and three in 2018 (3 %, $p < 0.05$). The median age of patients in the Covid-19 period was 11.5 months (IQR 6.8–24.5). Most patients were black (75 %) with public health insurance (75 %). All injuries were caused by blunt trauma, resulting in scalp/face contusions (63 %), skull fractures (50 %), intracranial hemorrhage (38 %), and long bone fractures (25 %).
Conclusions: There was an increase in the proportion of traumatic injuries caused by physical child abuse at our center during the Covid-19 pandemic. Strategies to mitigate this secondary effect of social distancing should be thoughtfully implemented.

Kovler, M. L., Ziegfeld, S., Ryan, L. M., Goldstein, M. A., Gardner, R., Garcia, A. V., & Nasr, I. W. (2021). Increased proportion of physical child abuse injuries at a level I pediatric trauma center during the Covid-19 pandemic. Child abuse & neglect, 116, 104756. [retrieved 19/12/2021]: https://www.sciencedirect.com/science/article/pii/S0145213420304117

The Impact of COVID-19 Traumatic Stressors on Mental Health: Is COVID-19 a New Trauma Type

Kira, I. A., Shuwiekh, H. A., Ashby, J. S., Elwakeel, S. A., Alhuwailah, A., Sous, M. S. F., ... & Jamil, H. J.

COVID-19 is a new type of trauma that has never been conceptually or empirically analyzed in our discipline. This study aimed to investigate the impact of COVID-19 as traumatic stress on mental health after controlling for individuals' previous stressors and traumas. We utilized a sample of (N = 1374) adults from seven Arab countries. We used an anonymous online questionnaire that included measures for COVID-19 traumatic stress, posttraumatic stress disorder, anxiety, depression, and cumulative stressors and traumas. We conducted hierarchical multiple regression, with posttraumatic stress disorder, depression, and anxiety as dependent variables. In the first step, in each analysis, we entered the country, gender, age, religion, education, and income as independent variables (Kira, Traumatology 7(2):73–86, 2001; Kira, Torture, 14:38–44, 2004; Kira, Traumatology, 2021, https://doi.org/10.1037/trm0000305). In the second step, we entered cumulative stressors and traumas as an independent variable. In the third step, we entered either COVID-19 traumatic stressors or one of its subtypes (fears of infection, economic, and lockdown) as an independent variable. Finally, we conducted structural equation modeling with PTSD, depression, and anxiety as predictors of the latent variable mental health and COVID-19 as the independent variable. Results indicated that COVID-19 traumatic stressors, and each of its three subtypes, were unique predictors of PTSD, anxiety, and depression. Thus, COVID-19 is a new type of traumatic stress that has serious mental health effects.

Kira, I. A., Shuwiekh, H. A., Ashby, J. S., Elwakeel, S. A., Alhuwailah, A., Sous, M. S. F., ... & Jamil, H. J. (2021). The impact of COVID-19 traumatic stressors on mental health: Is COVID-19 a new trauma type. International journal of mental health and addiction, 1-20. [retrieved 19/12/2021]: https://link.springer.com/article/10.1007/s11469-021-00577-0

Sequencing the Serotonergic Neuron Translatome Reveals a New Role for Fkbp5 in Stress

Lesiak, A. J., Coffey, K., Cohen, J. H., Liang, K. J., Chavkin, C., & Neumaier, J. F.

Serotonin is a key mediator of stress, anxiety, and depression, and novel therapeutic targets within serotonin neurons are needed to combat these disorders. To determine how stress alters the translational profile of serotonin neurons, we sequenced ribosome-associated RNA from these neurons after repeated stress in male and female mice. We identified numerous sex- and stress-regulated genes. In particular, Fkbp5 mRNA, which codes for the glucocorticoid receptor co-chaperone protein FKBP51, was consistently upregulated in male and female mice following stress. Pretreatment with a selective FKBP51 inhibitor into the dorsal raphe prior to repeated forced swim stress decreased resulting in stress-induced anhedonia. Our results support previous findings linking FKBP51 to stress-related disorders and provide the first evidence suggesting that FKBP51 function may be an important regulatory node integrating circulating stress hormones and serotonergic regulation of stress responses.

Lesiak, A. J., Coffey, K., Cohen, J. H., Liang, K. J., Chavkin, C., & Neumaier, J. F. (2021). Sequencing the serotonergic neuron translatome reveals a new role for Fkbp5 in stress. Molecular psychiatry, 26(9), 4742-4753. [retrieved 19/12/2021]: https://www.nature.com/articles/s41380-020-0750-4

The Association Between Childhood Trauma and Attachment Functioning in Patients with Personality Disorders

Voestermans, D., Eikelenboom, M., Rullmann, J., Wolters-Geerdink, M., Draijer, N., Smit, J. H., & van Marle, H. J.

Attachment (mal)functioning and a history of childhood trauma (CT) are both considered psychological determinants of personality disorders (PDs). Their interaction, however, remains largely uninvestigated. In this study, the authors assessed adult and childhood attachment style in a sample of patients with diverse PDs (N = 75) and determined the relation with both occurrence and severity of CT. The authors found that the sample was characterized by severe attachment malfunctioning and high levels of CT. Using cross-tabulations and analysis of variance, the authors showed that patients with a fearful or dismissive attachment style experienced more severe CT than patients with a preoccupied attachment style. Patients reporting an affectionless control bonding style to either parent suffered frequent and severe CT. Although temporal causality cannot be determined, these findings stress the necessity to screen for CT in PDs and suggest that attachment-centered psychotherapy for these patients may benefit from preceding or concurrent trauma treatment.

Voestermans, D., Eikelenboom, M., Rullmann, J., Wolters-Geerdink, M., Draijer, N., Smit, J. H., & van Marle, H. J. (2021). The association between childhood trauma and attachment functioning in patients with personality disorders. Journal of personality disorders, 35(4), 554-572. [retrieved 19/12/2021]: https://guilfordjournals.com/doi/abs/10.1521/pedi_2020_34_474

Intranasal Oxytocin Administration Impacts the Acquisition and Consolidation of Trauma-Associated Memories: A Double-Blind Randomized Placebo-Controlled Experimental Study in Healthy Women

Schultebraucks, K., Maslahati, T., Wingenfeld, K., Hellmann-Regen, J., Kraft, J., Kownatzki, M., & Roepke, S.

Intrusive memories are a hallmark symptom of post-traumatic stress disorder (PTSD) and oxytocin has been implicated in the formation of intrusive memories. This study investigates how oxytocin influences the acquisition and consolidation of trauma-associated memories and whether these effects are influenced by individual neurobiological and genetic differences. In this randomized, double-blind, placebo-controlled study, 220 healthy women received either a single dose of intranasal 24IU oxytocin or a placebo before exposure to a trauma film paradigm that solicits intrusive memories. We used a "general random forest" machine learning approach to examine whether differences in the noradrenergic and hypothalamic-pituitary-adrenal axis activity, polygenic risk for psychiatric disorders, and genetic polymorphism of the oxytocin receptor influence the effect of oxytocin on the acquisition and consolidation of intrusive memories. Oxytocin induced significantly more intrusive memories than placebo did ($t(188.33)=2.12$, $p=0.035$, Cohen's $d=0.30$, 95% CI 0.16–0.44). As hypothesized, we found that the effect of oxytocin on intrusive memories was influenced by biological covariates, such as salivary cortisol, heart rate variability, and PTSD polygenic risk scores. The five factors that were most relevant to the oxytocin effect on intrusive memories were included in a Poisson regression, which showed that, besides oxytocin administration, higher polygenic loadings for PTSD and major depressive disorder were directly associated with a higher number of reported intrusions after exposure to the trauma film stressor. These results suggest that intranasal oxytocin amplifies the acquisition and consolidation of intrusive memories and that this effect is modulated by neurobiological and genetic factors.

Schultebraucks, K., Maslahati, T., Wingenfeld, K., Hellmann-Regen, J., Kraft, J., Kownatzki, M., & Roepke, S. (2021). Intranasal oxytocin administration impacts the acquisition and consolidation of trauma-associated memories: a double-blind randomized placebo-controlled experimental study in healthy women. Neuropsychopharmacology, 1-9. [retrieved 19/12/2021]: https://www.nature.com/articles/s41386-021-01247-4

Childhood Trauma and Aggression in Persons Convicted for Homicide: An Exploratory Study Examines the Role of Plasma Oxytocin

Goh, K. K., Lu, M. L., & Jou, S.

Evidence has demonstrated the association between childhood trauma and criminality in adulthood, however, less is known about how best to explain the route from childhood trauma to adulthood aggression. Results from both human and animal studies have generated the hypothesis that dysfunction of the oxytocinergic system may correlate with pathological aggression. The current study represents a first exploratory examination to investigate the trajectory from childhood trauma to aggression, specifically, plasma oxytocin's role in this association. We assessed the childhood trauma experiences in a total of 108 participants, including 33 persons convicted for homicide and 75 non-offending healthy participants, using the Childhood Trauma Questionnaire, with in-depth clarification interviews for cross-validation. All participants were checked for aggression using the Modified Overt Aggression Scale and their plasma oxytocin levels were obtained. Results indicated that persons convicted for homicide had higher childhood trauma scores and lower plasma oxytocin levels than healthy controls. The plasma oxytocin levels were inversely correlated with childhood trauma in all participants. Further mediation models were constructed to explore these associations, in the best-fit model, the relationship between childhood trauma and aggression is mediated by plasma oxytocin levels in persons convicted for homicide. In conclusion, the association between childhood trauma and aggression of persons convicted for homicide is mediated by their plasma oxytocin levels. With leading to further theoretical consideration in the causality on how best to explain the interaction between childhood trauma and aggression, the current study may assist in developing further research and preventive strategies for aggression, particularly the importance of early identification of childhood trauma.

Goh, K. K., Lu, M. L., & Jou, S. (2021). Childhood trauma and aggression in persons convicted for homicide: an exploratory study examines the role of plasma oxytocin. Frontiers in psychiatry, 1402. [retrieved 19/12/2021]: https://www.frontiersin.org/articles/10.3389/fpsyt.2021.719282/full

Epigenetic Prediction of 17β-estradiol and Relationship to Trauma-Related Outcomes in Women

Hack, L. M., Nishitani, S., Knight, A. K., Kilaru, V., Maddox, S. A., Seligowski, A. V., & Michopoulos, V.

17β-estradiol (E2) levels in women correlate with multiple neuropsychiatric symptoms, including those that are stress-related. Furthermore, prior work from our group has demonstrated that E2 status influences DNA methylation (DNAm) across the genome. We developed and validated a DNAm-based predictor of E2 (one of four naturally occurring estrogens) using a training set of 183 females and a test set of 79 females from the same traumatized cohort. We showed that predicted E2 levels were highly correlated with measured E2 concentrations in our testing set ($r = 0.75$, $p = 1.8e\text{-}15$). We further demonstrated that predicted E2 concentrations, in combination with measured values, negatively correlated with current post-traumatic stress disorder (PTSD) ($\beta = -0.38$, $p = 0.01$) and major depressive disorder (MDD) diagnoses ($\beta = -0.45$, $p = 0.02$), as well as a continuous measure of PTSD symptom severity ($\beta = -2.3$, $p = 0.007$) in females. Finally, we tested our predictor in an independent data set ($n = 85$) also comprised of recently traumatized female subjects to determine if the predictor would generalize to a different population than the one on which it was developed. We found that the correlation between predicted and actual E2 concentrations in the external validation data set was also high ($r = 0.48$, $p = 3.0e\text{-}6$). While further validation is warranted, a DNAm predictor of E2 concentrations will advance our understanding of hormone-epigenetic interactions. Furthermore, such a DNAm predictor may serve as an epigenetic proxy for E2 concentrations and thus provide an important biomarker to better evaluate the contribution of E2 to current and potentially future psychiatric symptoms in samples for which E2 is not measured.

Hack, L. M., Nishitani, S., Knight, A. K., Kilaru, V., Maddox, S. A., Seligowski, A. V., & Michopoulos, V. (2021). Epigenetic prediction of 17β-estradiol and relationship to trauma-related outcomes in women. Comprehensive Psychoneuroendocrinology, 6, 100045. [retrieved 19/12/2021]: https://www.sciencedirect.com/science/article/pii/S2666497621000199

Childhood Trauma, the Combination of MAO-A and COMT Genetic Polymorphisms and the Joy of Being Aggressive in Forensic Psychiatric Patients

Fritz, M., Rösel, F., Dobler, H., Streb, J., & Dudeck, M.

Aggression and violent offenses are common amongst forensic psychiatric patients. Notably, research distinguishes two motivationally distinct dimensions of aggression–instrumental and reactive aggression. Instrumental aggression comprises appetitive, goal-directed aggressive acts, whereas reactive aggression consists of affective, defensive violence with both their biological basis remaining largely unknown. Childhood trauma and functional genetic polymorphisms in catecholamines converting enzymes, such as mono-amino-oxidase A (MAO-A) and catechol-o-methyltransferase (COMT) have been suggested to augment an aggressive behavioral response in adulthood. However, it warrants clarification if these factors influence one or both types of aggression. Furthermore, it remains elusive, if having a combination of unfavorable enzyme genotypes and childhood maltreatment further increases violent behavior. Hence, we set out to address these questions in the current study. First, analysis revealed an overall marginally increased frequency of the unfavorable MAO-A genotype in the test population. Second, each gene polymorphisms together with a traumatic childhood significantly increased the AFAS (Appetitive and Facilitative Aggression Scale) scores for both reactive and appetitive aggression. Third, having a combination of both disadvantageous genotypes and a negative childhood served as a minor positive predictor for increased reactive aggression, but had a strong influence on the joy of being aggressive.

Fritz, M., Rösel, F., Dobler, H., Streb, J., & Dudeck, M. (2021). Childhood Trauma, the Combination of MAO-A and COMT Genetic Polymorphisms and the Joy of Being Aggressive in Forensic Psychiatric Patients. Brain sciences, 11(8), 1008. [retrieved 19/12/2021]: https://www.mdpi.com/2076-3425/11/8/1008

Sexual Abuse and Physical Neglect in Childhood are Associated with Affective Theory of Mind in Adults with Schizophrenia

Vaskinn, A., Melle, I., Aas, M., & Berg, A. O.

Whereas childhood trauma is associated with reduced nonsocial cognition in schizophrenia, research on the relationship between childhood trauma and social cognition is limited and mixed. The aim of this study was to examine the association between childhood trauma and theory of mind (ToM) in persons with schizophrenia (n = 68) compared to healthy control participants (n = 70). Childhood trauma was assessed with the Childhood Trauma Questionnaire (CTQ), providing information on physical abuse, emotional abuse, sexual abuse, physical neglect and emotional neglect. ToM was indexed by the Movie for the Assessment of Social Cognition (MASC), which yields scores for total, cognitive and affective ToM, and for three error types (overmentalizing, undermentalizing, no mentalizing). Persons with schizophrenia had elevated rates of childhood trauma and lower ToM scores than healthy controls. In the schizophrenia group, associations between sexual abuse and affective ToM was statistically significant. In regression analyses, physical neglect was found to be the strongest predictor of affective ToM. In healthy controls, childhood trauma was not associated with ToM. Follow-up analyses comparing individuals with/without clinically significant childhood trauma, confirmed the findings for the schizophrenia group. No causal inferences can be made in this cross-sectional study, but the results suggest an illness-specific association between both sexual abuse and physical neglect in childhood, and adult affective ToM in individuals with schizophrenia.

Vaskinn, A., Melle, I., Aas, M., & Berg, A. O. (2021). Sexual abuse and physical neglect in childhood are associated with affective theory of mind in adults with schizophrenia. Schizophrenia Research: Cognition, 23, 100189. [retrieved 19/12/2021]: https://www.sciencedirect.com/science/article/pii/S2215001320300342

Health and Financial Costs of Adverse Childhood Experiences in 28 European Countries: A Systematic Review and Meta-Analysis

Hughes, K., Ford, K., Bellis, M. A., Glendinning, F., Harrison, E., & Passmore, J.

Background: Adverse childhood experiences (ACEs) are associated with increased health risks across the life course. We aimed to estimate the annual health and financial burden of ACEs for 28 European countries.
Methods: In this systematic review and meta-analysis, we searched MEDLINE, CINAHL, PsycINFO, Applied Social Sciences Index and Abstracts, Criminal Justice Databases, and Education Resources Information Center for quantitative studies (published Jan 1, 1990, to Sept 8, 2020) that reported prevalence of ACEs and risks of health outcomes associated with ACEs. Pooled relative risks were calculated for associations between ACEs and harmful alcohol use, smoking, illicit drug use, high body-mass index, depression, anxiety, interpersonal violence, cancer, type 2 diabetes, cardiovascular disease, stroke, and respiratory disease. Country-level ACE prevalence was calculated using available data. Country-level population attributable fractions (PAFs) due to ACEs were generated and applied to 2019 estimates of disability-adjusted life-years. Financial costs (US$ in 2019) were estimated using an adapted human capital approach.
Findings: In most countries, interpersonal violence had the largest PAFs due to ACEs (range 14·7–53·5%), followed by harmful alcohol use (15·7–45·0%), illicit drug use (15·2–44·9%), and anxiety (13·9%–44·8%). Harmful alcohol use, smoking, and cancer had the highest ACE-attributable costs in many countries. Total ACE-attributable costs ranged from $0·1 billion (Montenegro) to $129·4 billion (Germany) and were equivalent to between 1·1% (Sweden and Turkey) and 6·0% (Ukraine) of nations' gross domestic products.
Interpretation: Availability of ACE data varies widely between countries and country-level estimates cannot be directly compared. However, findings suggest ACEs are associated with major health and financial costs across European countries. The cost of not investing to prevent ACEs must be recognised, particularly as countries look to recover from the COVID-19 pandemic, which interrupted services and education, and potentially increased risk factors for ACEs.

Hughes, K., Ford, K., Bellis, M. A., Glendinning, F., Harrison, E., & Passmore, J. (2021). Health and financial costs of adverse childhood experiences in 28 European countries: a systematic review and meta-analysis. The Lancet Public Health, 6(11), e848-e857. [retrieved 19/12/2021]: https://www.sciencedirect.com/science/article/pii/S2468266721002322

DATES FOR YOUR DIARY IN 2021/2022

Online two day Workshop Treating Chronically Traumatized Children with the Sleeping Dogs method to overcome barriers to traumatreatment.
Date 14 December 2021 and 14th January 2022
Time: 9.30-16.30 Central European Time in Dutch
Presenter: Arianne Struik
Contact: ictc@ariannestruik.com
Website/register: www.ariannestruik.com

On line Hybrid Course:

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

Living Legend Webinar
How to Work with Persecutory and Malevolent Introject Alters
Date: December 3, 2021
Presenter: Colin Ross
Webinar Details | Register Now!

ISSTD Nashville Regional Conference
DoubleTree Nashville Downtown | Nashville, TN (USA)
Date: December 9-10, 2021

Online Workshop : Treating Chronically Traumatized Children with the Sleeping Dogs method to Overcome barriers to trauma treatment.
Date: December 14, 2021
Presenter: Arianne Struik
Contact: ictc@ariannestruik.com
Website/register: www.ariannestruik.com

Online training: Addressing Psychological Defenses in the Psychotherapy of Complex Trauma and Dissociation
Dates: January 15, February 5, March 12 & April 20, 2022
Presenters: Kathy Steele & Dolores Mosquera
https://www.intra-tp.com/wp-content/uploads/2021/09/Defenses-training-Steele-Mosquera-new-dates.pdf

Webinar: The Trauma and Dissociation Symptoms Interview (TADS-I): Introduction and updated information
Date: Thursday, January 20th 2022
Presenter: Suzette Boon, PhD
Register: ESTD website

Webinar: Differential Diagnosis of Dissociation and Dissociative Disorders: Epidemiology, Lessons from History, Cumulative Trauma, and Mental Status Exam
Date: March 17th, 2022.
Presenter: Richard J. Loewenstein, Clinical Professor
Register: ESTD website

Complex trauma and dissociation across the lifespan
EMDR UK annual conference.
Dates: March 25 & 26, 2022
Ana Gomez, Dolores Mosquera & Kathy Steele
https://emdrassociation.org.uk/wp-content/uploads/2021/03/EMDR-2022-Conference-Flyer.pdf

ISSTD 39th Annual Conference
Post-Traumatic Growth in a Dissociative World
Pre-Conference: March 31 – April 1, 2022 | Main Conference: April 2-4, 2022
Hyatt Regency Seattle | Seattle, WA USA
Registration: ISSTD. Registration Opens December 2021

EMDR Europe Workshop Conference
Dates: 10 – 12 June, 2022
Valencia, Spain & Virtual
The 2022 Conference's theme will focus on promoting resilience with EMDR.
https://emdr2022.com/

Onsite training: Treating dissociative disorders with EMDR: the progressive approach / Traiter les troubles dissociatifs avec l'EMDR : l'approche progressive
Dates: June 24 & 25, 2022
Place: Paris, France
Presenter: Dolores Mosquera
Registration: https://www.ifemdr.fr/traiter-les-troubles-dissociatifs-avec-lemdr-lapproche-progressive/

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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