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ESTD NEWSLETTER

Co-editors: Dolores Mosquera, Onno van der Hart, Orit Badouk-Epstein.

Volume 8 Number 3, September 2019

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QUARTERLY QUOTE

"TREATMENT STRATEGIES THAT INVOLVE IGNORING OR GETTING RID OF HOSTILE VOICES (1)

These strategies "involve avoiding issues or emotions the voices are expressing." A key aspect of the work with hostile parts of the personality and voices is to listen and understand their function and the meaning behind their disruptive behaviors. The less we listen and the more the voices are ignored, the more they tend to scream or escalate..."

Dolores Mosquera & Colin Ross (2016, p. 2)

Anca Vilma Sabau
ESTD President

LETTER FROM THE PRESIDENT

Dear ESTD members,

Summer holidays are over and I hope all your batteries are recharged. In many countries September and October are a time for training programmes, workshops and conferences. Our Biennial ESTD Conference looks promising with an exciting list of researchers and skilled clinicians from all over the world with intriguing presentations, ranging from assessment and diagnosis to treatment methods and research presentations. You can still register for the different levels of participation available: complete conference, pre-conference workshops, or just for a single day. You are also invited to the terrace of the Hotel Forum (offering a magnificent view of the Roman Forum) to mingle with colleagues from places far and close in a pleasant and relaxing atmosphere.

The single most important development in the past few months has been the online launching of the mentoring program. You can access this on the this link http://estd.org/estd-mentors
There are still details to be finalised before we start running the program. The first online module on treatment developed by Dr Anabel Gonzalez will also be available soon for clinical use.

As I am writing, the election of the new Board is still in progress. As soon as the results are known official notifications will be sent out.

Generally, the health system and social programs in East and Central European countries are still in need of major overhaul. In Romania, for example, even thirty years after the Revolution, the health system remains archaic and dysfunctional – largely unresponsive to the population's health care needs. There is little appropriate response to the consequences of trauma. The need for change is urgent, especially in the development and implementation of preventative programs, trauma assessment, and appropriate, evidence-based contemporary treatment regimes. All the more so, because trauma and dissociation are common problems in this part of the world.
We, Romanian clinicians and academics, are thankful for what ESTD trainers (Drs Suzette Boon, Eli Somer, Ellen Jepsen, Anabel Gonzalez, Anna Gerge, Renee P. Marks, Bruce Perry) have contributed over the past years in training and supporting us to be able to make a difference to our patients at the grass-roots.

Similar work is done in other countries in our region, notably in Poland and in Hungary. It is our ardent hope that the ESTD will grow and become more capable at a European level in offering coherent programs for teaching in trauma and dissociation. Our numbers are growing and so is our desire to best fulfil the needs of our members.

With best wishes,

Anca Vilma Sabau, MD
President, ESTD

NEWS

Dear ESTD members,
If you come across news relevant to our field, we would like to invite you to send us a short bulletin: brief information that you might think is significant and relevant to our work with trauma and which has sparked some public interest.
In this issue we share Nancy Borret's heartfelt email to ESTD-UK from July 24th.

On the 24th July , Nancy Borrett wrote a heartfelt email on the ESTD-UK listserve.

"Dear all,
I'm sure I'm not alone in feeling dismayed about the recent media coverage of 'Nick' (Carl Beech) and subsequent media vilification of him, Operation Midland, Tom Watson etc. Just to clarify, I have no personal knowledge of him or the case and cannot comment on the facts as presented.

However, I am aware that many of us have met survivors who report similar experiences to his.


Carl Beech

A particularly disturbing outcome of the media coverage is the strongly expressed view that, "Police must end the victim culture to prevent more reputations being ruined through false claims" (MSN news quote)- the victim culture, apparently, being the concept of starting from a point of listening to and believing victims of abuse.

It is interesting to me that this is happening at a time when IICSA is bringing to light the reality of numerous organised historic paedophile rings,

including members of the establishment being named, yet no mention of this or links are being made in the media (as far as I can see).

I am concerned about the impact this will have on survivors considering coming forward or those already in the justice system or involved with IICSA. I wondered if- as a professional group who have an understanding of trauma and dissociation, often working with survivors of extreme abuse - we should or could submit a jointly-signed letter or statement expressing concern about this? Or is there something else we can do?

It's hard to act solo on this due to client confidentiality, apart from anything else. And a group has more power potentially.

Your thoughts would be welcomed.
Best wishes Nancy

In response to that I posted a piece I had written and intended to submit as a letter of opinion piece to The Guardian. Immediately there was an upsurge of interested people willing to add their name and a rare process of communal editing began after which there were 33 signatories to the letter as well as good wishes and ideas from those who could not publicly sign.
5 days later after hours and hours of editing in different comments the piece was published in the Guardian.

Letters to the Guardian

Trauma and abuse evoke powerful feelings and we are concerned that the extra anger being aimed at Tom Watson MP, the police and Carl Beech is missing adequate reflection.

Tom Watson suggested, in parliament 2012 , that evidence from the paedophile Peter Righton's conviction pointed to a "powerful paedophile network linked to Parliament and No 10". This was prior to speaking to Beech and he was right. National figures such as Jimmy Savile and Cyril Smith MP were unmasked as prolific child abusers. The outcry culminated in Home Secretary Theresa May announcing an independent inquiry and the 2014 pressuring on police to be believing- now rescinded .

The kind of scenarios Carl Beech describes and his complex mixture of untreated victim and perpetrator are familiar.

People need to understand "fantasists"and "liars". To ignore that subject risks not hearing vulnerable children. Children with dissociative identity disorder from trauma, for example, are often accused of being liars when one state of mind is amnesic to what another has said or done.

To be wrongly accused is abuse . We must provide justice for all whilst acknowledging the number of innocent people named is very small compared to 1 in 65 survivors who gain justice.

Meanwhile, as one survivor of parliamentary abuse commented, "When Tom Watson spoke I felt I could vote, and visit parliament. But if he is attacked for doing the right thing- and "Nick" is imprisoned for so long ,what would happen to me? "

We seek justice for all ,thorough investigation and an awareness of mental health needs.

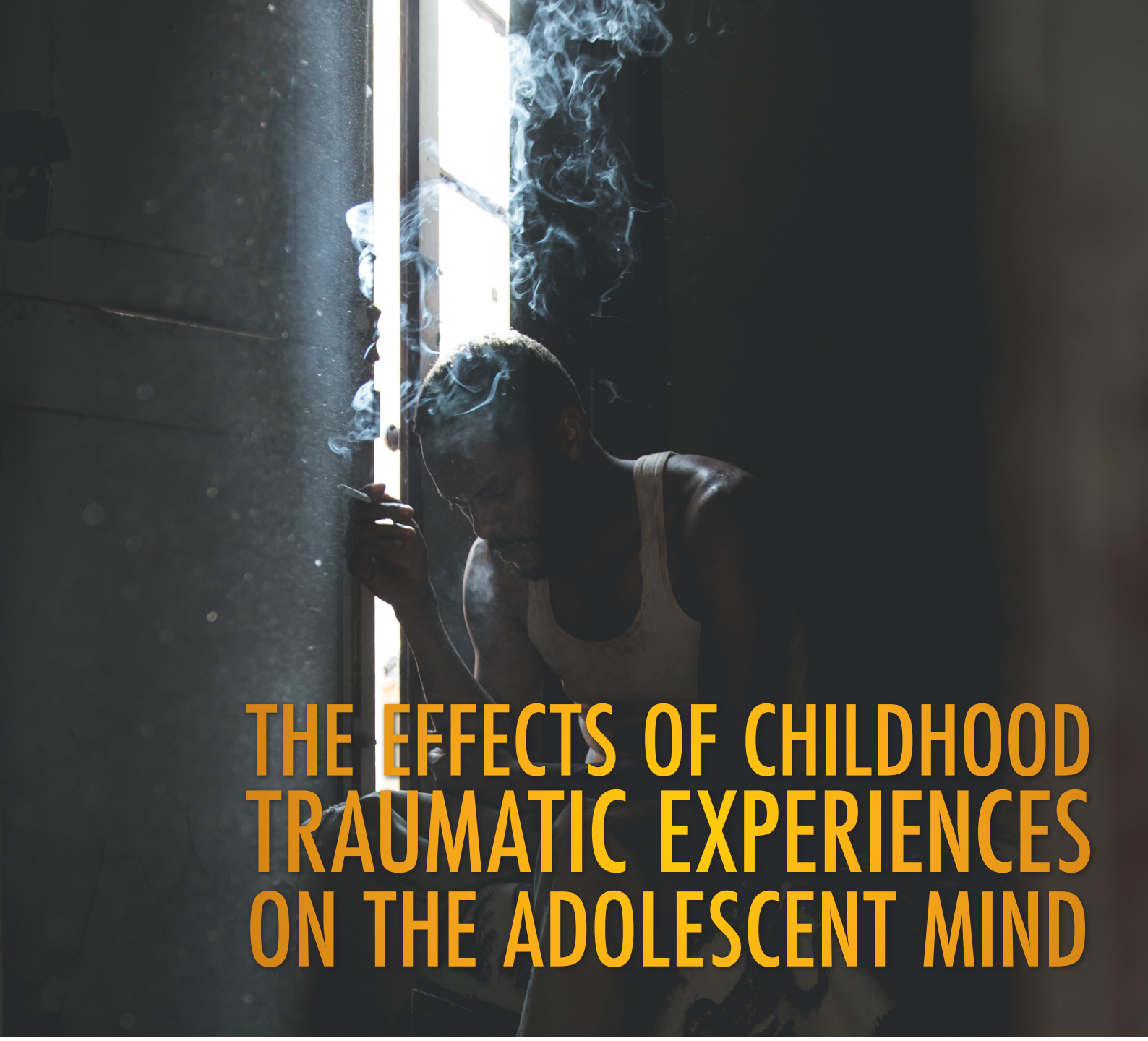
We give permission for our names to be printed. All signatories are therapists,psychologists, and counsellors.

Dr Valerie Sinason, Sue Richardson, Kathryn Livingston, Melanie Goodwin, Rémy Aquarone, Nancy Borrett, Jaclyn Everitt, Andrew Baxter, Penny Johnson, Paula Fenn,Dena Sanger, Ruth Alborough, Kay Luck, Maire Fitzmaurice, Michelle Jowett, Winja Lutz, Dr Sandra Buck, Judy Williams, Lindsay Schofield, Dr Kate Forbes Pitt, Dehra Mitchell, Dr. Eimir McGrath, Andrea Aldridge, Dr Liz Hall, Mandy Coghill, Ronete Cohen, Giles Lascelle, Abbie O'Connor, Jane Blackhurst, Cathie Wright, Ruth Leaper, Patricia Bahs, Katia Kohler, Dr Loraine Newbold, Paula Biles, Dr Rainer Kurtz, Judith Marlow, Heather Bacon

ESTD launched a Facebook page this summer!

It features news about the upcoming conference in Rome, other trainings and workshops, links to recent scientific articles, quotes, and older articles (2008–2016) from the ESTD newsletter!

Please like our page https://www.facebook.com/estdinfo/ and share its posts with your contacts!



THE EFFECTS OF CHILDHOOD TRAUMATIC EXPERIENCES ON THE ADOLESCENT MIND

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Abstract

Adolescence is a life period characterized by significant neurobiological changes and neurodevelopmental challenges; this makes the adolescent mind particularly sensitive to the emergence of mental health disorders. Traumatic events experienced during childhood can further increase the risk of developing a mental disorder in adolescence, this may unfold in the shape of various dysfunctional behaviours and disorders such as alcohol and substance abuse, anxiety, depression, self-harm, sexualised behaviours, aggression, high levels of control and PTSD. Dissociative symptoms like derealization and depersonalization are also extensively investigated in relation to childhood traumatic experiences, differently, auditory hallucinations are mostly considered by mental health practitioners as exclusive indicators of a

psychotic disorder and unlikely to be linked to a dissociative experience consequent to a severe traumatic event. Conversely, evidence suggests that auditory hallucinations are often present among patients who have experienced a severe trauma during childhood and among non-psychotic patients diagnosed with a dissociative disorder. In these cases, hallucinations may therefore be considered dissociative symptoms themselves. In support of this view, we discuss here a brief review of literature and two clinical vignettes.

According to the World Health Organization, 10–20% of adolescents worldwide experience mental health conditions (WHO, 2018). Data from the National Comorbidity Survey Replication study, investigating a representative sample of over 9 000 people in the United States, has identified the peak age of onset for mental disorders at 14 (Kessler et al., 2005), although the age of onset is progressively decreasing. Anxiety disorders, depression, psychotic disorders and substance abuse are all disorders that frequently emerge during the first years of adolescence and young adulthood (Kessler et al., 2005; Häfner et al., 1989). Early age of onset is also associated with a greater severity of the disorder (Kessler, Keller & Wittchen, 2001), to a greater persistence (Clark, Jones, Wood, & Cornelius, 2006) and to a diminished treatment response (Nierenberg, Quitkin, Kremer, Keller, & Thase, 2004). This evidence suggests that early onset mental health disorders should be considered, viewed and treated with special concern as compared to adult disorders, and that a prompt intervention is needed in order to ensure the best possible outcome for the adolescent seeking help.
Among those who seek mental health assistance, previous traumatic experiences are extremely frequent; it has been estimated that between 87% and 47% of individuals needing mental health treatment have experienced at least one significant traumatic event in their lifetime (Cusack, Grubaugh, Knapp, & Frueh,2006; Mauritz, Goossens, Draijer & Van Achterberg, 2013). The consequences of complex trauma experienced during childhood often become explicit during adolescence, also due to the arising neurobiological changes and developmental challenges that the individual is faced with throughout this life period.

The effects of trauma on the adolescent mind can be multifaceted. Adolescents with alcohol abuse or dependence have been estimated to be 6 to 12 times more likely to have experienced adverse childhood events such as physical abuse and sexual abuse as compared to control subjects (Clark, Lesnick & Hegedus, 1997).

Physical abuse has also been reported to produce a greater risk for depression, anxiety, Post Traumatic Stress Disorder (PTSD) and Oppositional Defiant Disorder (ODD) in adolescence (Pelcovitz , Kaplan, DeRosa, Mandel & Salzinger 2000).

Dissociative symptoms are also extensively present in adolescents who have experienced childhood traumatic experiences. Symptoms such as depersonalization and derealization in adolescence have been reported to often arise as a consequence of childhood abuse (Lanius, Brand, Vermetten, Frewen, & Spiegel, 2012; Lanius et al., 2010). Patients suffering from dissociative disorders often also suffer from PTSD, which has been estimated to be comorbid with dissociation in 88% to 97% of cases (Foote, Smolin, Neft & Lipschitz, 2008; Rodewald, Wilhelm-Göling, Emrich, Reddemann, & Gast, 2011). This evidence suggests that dissociative symptoms often arise as a consequence of previous traumatic experiences; however, the construct of dissociation has been questioned worldwide in terms of what should be considered a dissociative disorder and which perceptual experiences are to be included in the definition of "dissociative symptoms" (Brown, 2006; Dell, 2009; Holmes et al., 2005).

Psychotic-like symptoms such as auditory hallucinations, for example, are typically considered as indicators of a psychotic disorder. However, evidence has revealed that auditory hallucinations may be found in 47% to 90% of patients with a dissociative disorder (Ross et al., 1990; Kluft, 1987; Boon, & Draijer, 1993). This suggests that, although

hallucinations can sometimes be considered a psychotic symptom, this may not necessarily always be the case, especially in those individuals who have experienced severe traumatic experiences during their childhood that may have resulted in what has been defined as a "fragmented self"; in these cases, auditory hallucinations may be considered as dissociative symptoms and therefore treated accordingly.

The construct of hallucinations as dissociative symptoms is supported by robust evidence linking previous traumatic experiences and the emergence of psychotic symptoms in adolescence; a study on 211 adolescents between 12 and 15 years old revealed that those who reported psychotic symptoms were significantly more likely to report an experience of physical abuse, domestic violence or bullying during childhood (Kelleher et al. 2008). Interestingly, a recent study investigated the association between maltreatment and psychotic symptoms in schizophrenic patients and non-psychiatric controls; findings revealed that the positive correlation found between childhood traumatic experiences and psychotic symptoms was positive and significant not only in the psychotic group but also in the group of individuals who had not developed a psychotic disorder. This suggests that the presence of abnormal psychic experiences (i.e., hallucinations) following trauma is not necessarily dependent on the presence vs. absence of a proper psychotic disorder (DeRosse, Nitzburg, Kompancaril, & Malhotra, 2014).

In line with this evidence, Moskowitz and Corstens (2008) have questioned the line of thought that views auditory hallucinations exclusively as a core psychotic symptom, and highlight how people who are not psychotic may hear voices, especially following serious traumatic events.

This evidence suggests that hallucinations may be considered as dissociative symptoms, especially in situations where severe trauma has been experienced. This may particularly be true in the case of adolescents whose mind is still extremely fluid. When investigating this developmental period, signs and symptoms should not be considered as having the same diagnostic value as the ones emerging in or protracting though adult age: they can evolve and progress according to different trajectories, depending on what has caused them and how we intervene to treat them. For this reason, care must be taken in the definition of a differential diagnosis, which necessarily needs to go beyond the definition of symptoms for its evaluation and needs to take into consideration the way the individuals live the symptoms themselves subjectively. Here, we present two clinical vignettes of individuals reporting auditory hallucinations.

Vignette 1

D. is 17 years old. He arrives at the service due to an anxious state upon recommendation of the family doctor Symptoms include auditory hallucinations of commenting and insulting voices, with threatening and persecutory content; he reports ideas of reference (i.e. neutral events assume a strong personal significance) He is preoccupied with things he has done in the past and with what could happen to him in the future; he is also afraid he may harm people he loves. D. is withdrawn socially and has never entertained any sexual relationship. At neurocognitive testing, he demonstrates severe difficulties in long-term visuospatial memory tasks and moderate difficulties in long-term verbal memory tasks. He demonstrates mild difficulties in simple constructive praxis trials and in short-term verbal memory tasks. Logical-deductive reasoning, attention and information processing also appear impaired.

Vignette 2

C. is 18 years old and has been admitted to hospital following psychomotor agitation, significant mental distress and auditory hallucinations with a derogatory content. She refers the belief that someone is following her on the street (she claims she can feel a male presence constantly spying on her) with the intention to rape her. She is extroverted, has numerous friendships and is sexually active. Her symptoms started in middle

school (self-harm) following episodes of bullying. She also reports panic attacks and bulimic episodes during high school. At neurocognitive testing, C. reveals a slightly lower than average performance on an executive functions task. All other areas examined are within the normal range.

The apparently similar symptomatology described in the two vignettes is in fact attributable to two different psychopathological configurations: the first one belongs to the area of psychotic disorders; the second one reflects the presence of a dissociative disorder. This highlights how the same symptom may potentially indicate two distinct psychopathological frames. This is particularly true in developmental periods like adolescence. In the vignettes presented, the formulation of the correct diagnosis was possible following a wider and prolonged observation of the patients and their history. In the first case outlined, the patient referred to ideas of reference, social withdrawal and widespread neurocognitive difficulties, which suggested the presence of a core impairment. These symptoms, along with a thorough investigation of the relation the patient maintained with the voices themselves (e.g., the persecutory content) facilitated the formulation of a diagnosis of psychosis.

In the second vignette, the patient did not present significant neurocognitive difficulties and did not display social withdrawal. This, together with an investigation of the patient's previous history, allowed the clinician to identify the auditory hallucinations as a dissociative symptom.

A correct differential diagnosis in these cases is vital in order to implement the appropriate therapeutic intervention for each single case. Particular caution should be taken when pharmacological intervention is involved.

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DON'T TURN AWAY: NAME IT; NORMALISE IT; ACCEPT THE WHOLE CHILD.

By: Lynne Ryan

At the ESTD conference in York 2019, Dr Elly Hanson presented on a societal phenomenon of turning away from the reality of child and adult sexual abuse, in a presentation named: "Turning away: how and why do communities, deny, distance and minimise child sexual abuse?". Within this presentation was a quote from Herman (1992), "When traumatic events are of human design, those who bear witness are caught in the conflict between victim and perpetrator. All the perpetrator asks is that the bystander do nothing. He appeals to the universal desire to see, hear, and speak no evil. The victim, on the contrary, asks the bystander to share the burden of pain. The victim demands action, engagement and remembering".

This resonated greatly with me as a trauma specialist, working in the field of child sexual abuse for many years. A repetitive theme throughout my own direct work and that of my supervisees and indeed colleagues in this field, is a similar notion of not wanting to believe and turning away in the therapeutic space. This feels like an instinctual and reflexive wish to not see or hear, the horror of what is presented directly in front of us. This is particularly true with childhood sexual abuse, although not limited to that form of trauma.

This reminded me of working with a five-year-old boy early in my career, who had experienced pre-verbal chronic sexual abuse by his birth father. My theoretical therapeutic approach at that time was primarily nondirective play therapy and within

this, the child preferred to utilise animal puppets. On this particular occasion, he was playing out a scene with several animals, when he took the small elephant puppet and overtly thrust two fingers quickly and repeatedly in and out of the elephant's bottom. This occurred in a matter of seconds before he moved on to pick up a different toy and the play became more benign. I distinctly remember my own internal response of confusion as to what I had just witnessed, along with conflicting feelings of disbelief and questioning of what I had just seen front of my eyes. There was a desire to dismiss an interpretation of what the child had just shared with me, that this might have been, in fact, a trauma play re-enactment of his own experience. (I later verified that digital penetration formed part of his abuse at the hands of his birth father).

As a relatively inexperienced therapist in trauma work, I floundered and deliberated in formulating a response which culminated in me making no response. Neither did I make any acknowledgement or reflection to the child regarding what I had just seen – I turned away.

Almost 20 years on, from practicing in this field, my response now would be very different. However, I'm reminded of this mistake, as it is a repetitive theme in the work of my supervisees who question: Did I just see that? Was that what I just thought it was? Am I able to acknowledge my internal feelings, responses and what my own body is telling me about the need to accept and acknowledge the child's truth? All this occurs in milliseconds, before reaching a rational filter of a thinking brain, sculpted in a society where 'turning away' is not only encouraged, but the norm.

This is a brief personal vignette, which illustrates a strong desire to turn away in the place (the therapy space), in the very place where the opposite should be true. However, the therapy room is not a vacuum but is influenced by the personal, the political and societal influences of the current time.

The wisdom that comes with experience and with repetitive hearing and seeing of horrific pervasive and relentless abuse and torture of our most vulnerable humans, i.e., children, means that fortunately in my practice, I am now more able to give what I hope is a more appropriate and empathic response, where I am able to acknowledge, to name, to normalise and to accept, the child upon whom these atrocities have been committed.

In practice, it may be helpful to share my responses to supervisees who bring similar dilemmas. Firstly, it's important to acknowledge the conflict, the horror and often the disgust felt and experienced in the therapist, resulting from the information being imparted. I feel the need to emphasise that this is not disgust with the child, but with the facts of what another human is capable of doing to the vulnerable child. This information has to be received, believed, contained, witnessed and given back to the child in a way that conveys: "I hear you", "I see you", "I believe you", "I know that this happened to you", "This was not your fault", "This is not okay", "We can deal with this", "You can recover from this", "This does not have to define the rest of your life", "You are a remarkable human being", "You have survived this and this has changed you, but you are able to move forward in your life and be who you are meant to be".

In my earlier example, how would I have conveyed all of the above in the seconds following my eyes, ears and my body receiving the information before me?

Clearly this scenario is one that I have often reflected on placed in that rather full file named: "Therapeutic mistakes / I wish I had done this differently/ I am always learning".

So, with all my vast experience of numerous mistakes, how would I hope to respond? It would be helpful to use the words of the title as a guide: **"Name It; Normalise It; Accept the Whole Child".**

Name It.

Chopra (1996), stated, "There are no accidents... there is only some purpose that we haven't yet understood." I often hear that sentence in my head when I witness something and find myself

questioning my own eyes. Did that child accidentally thrust his fingers into the bottom of that puppet, at that moment, in my presence? Or is he indeed sharing with me something painful and shocking that was part of his own experience?

My current stance, based on years of work experience and training, would be that it is the latter. So, what would I have said and done differently? First of all, naming, in a curious and wondering way, what I had just seen, for example, "I see that you have just moved your fingers in and out of that elephants bottom". This may have been enough for the child to understand that his therapist has just said: "I see you". It may then be, depending on the child's response, that this could be explored further, "I wonder how that felt, I wonder what that was about?"

Some children who are also steeped in the societal wish to 'turn away', may quickly respond with their bodies and move away with a number of reflexive responses: a flight response, avoidance or distraction, a fight response, a dissociative response or even, utilising a higher brain response with words, "No I didn't: that wasn't me; shut up".

I believe a primary task of the therapist, is to stay with the child and to remain calm and curious and authentic. Not a tall order at all?! Humour aside, working with traumatised children is privileged and expert work, and our investment in ourselves as therapists, in our training and in our wish to, 'not turn away', is what we must draw on in these situations.

Normalise It.

The child's revelations in therapy often take great courage and deserve to be seen and named, but also, it's helpful to normalise the experience and this should form part of any psychoeducation within a trauma-informed approach, embedded in the initial stage of therapy, and weaved through subsequent work. This normalisation is conveying to the child that unfortunately, abuse experiences are common in a society which does not value or listen to children. How this might be said in practice, may be a response of, "I work with lots of children who have been hurt, and some of those have been hurt in the way that you just showed me with the elephant". The response is child led and any exploration is dependent upon the therapeutic relationship and the stage in the therapeutic process. It will be important to also establish where the child learned about this action, in order to move closer to the context of the incident and finally the child's own subjective experience.

Some children react to this with curiosity and astonishment, often previously having felt that they are alone with these experiences, which tend to exacerbate those feelings of "it's my fault", "it must be something I did", "I deserve this", etc.

This is the purpose of psychoeducation: to normalise feelings and reactions to trauma and trauma responses. (Psychoeducation is another topic which will be explored in further detail in a separate article.)

Following naming and normalising what has been witnessed, is the need to:

Accept the Whole Child.

This wording is deliberate as will be explained. In accepting the child, we need to convey whatever horror they have experienced, whatever behaviours they have shown, we accept them and that our relationship remains intact. This is not condoning unacceptable behaviours, but it is giving the message that there is nothing that the child can say or do that would make the therapist reject them, while also conveying that the therapist can manage whatever the child reveals. Again, we need to show this in our body language as well as in our words, as traumatised children are finely attuned to our non-verbal signals as well as to what is said. In practice, again referring to the earlier vignette, it would be important to calmly and empathically receive the child's material and ideally be able to convey or even say, "I know what happened to you and there is nothing that would make me like you any less or make me feel bad things about you. What happened was not okay, what happened shouldn't have happened, and adults should not do what they

did to you. Sometimes you're angry about this and that's okay, sometimes you do things that get you in trouble, that's why you're here in therapy, so that we can work some of that stuff out."

As an aside here, it's important that children are given permission to express feelings, in particular angry feelings, which appear to be taboo in our society. One of the roles of the therapist, is to assist children to be able to express feelings in appropriate and safe ways.

To summarise, acceptance of the child is key to the therapeutic relationship and therapeutic progress.

Following on from this, often traumatised children wish to disown parts of the self, which contain traumatic, painful, shameful experiences and wish to be seen as, "good", as well as unaffected and not caring about their experiences, and may say, "I don't care/ I'm not bothered".

There is huge variance in the way that trauma reactions manifest in children, since trauma impacts each individual in a unique way, depending upon their life experiences prior to the event(s.) It's therefore unsurprising that the child's responses, functioning and behaviour is also unique to them. It's important, then, that our therapeutic interventions respect this uniqueness and observes the notion, "one size does not fit all".

Unfortunately, our responses to the traumatised child, again on an individual and societal level, give a message of what is acceptable and unacceptable, so that the child with a more compliant or dissociative presentation and functioning in response to trauma, may, 'fly under the radar'. These responses may even be encouraged and valued, whereas the child who presents as aggressive, is perceived more negatively, although this child is 'seen' more quickly, in every sense of the word.

Therefore, we do a child a huge disservice if we convey the message that we value one trauma response over another. Rather, we should be honouring the child's presentation as their own unique and often creative strategy, to coping with their own traumatic experiences. Using a dissociation lens, we know that parts of the child often take various traumatic experiences or elements of, in order to ensure that the child survives. What this may then look like, is a child who can present as calm and helpful in one instance and angry and aggressive in another, over and above normal fluctuations in state and feeling. Unfortunately, an adult response to these switches and presentations which I often hear is, "I like the good Henry, can we have him back please? I don't like this angry Henry at all".

This is unhelpful when dealing with traumatised children and can lead to further entrenchment of dissociation. A more appropriate response would be to acknowledge the angry part and value the role that that part took in ensuring the child's survival.

We, as adults, need to accept the 'Whole Child', the angry, the sad, the aggressive, the shamed, the hurting, the sexualised and all those parts of the child, in addition to the 'more acceptable', kind, helpful, caring parts, that might in that moment rather act like an ANP (Apparently Normal Part of the Personality) (Van Der Hart, Nijenhuis & Steele, 2006). The child needs to know that those parts perceived as negative and unacceptable, actually had an important role and need to be validated, thanked and integrated, rather than dismissed and rejected.

So, in summary, our duty as therapists and counsellors working with child (and adult) trauma, is to be open to making mistakes and learning from them. We then need to equip ourselves so that we can Name what we see, to Normalise those trauma reactions and to Accept the Whole Child, no matter what.

You may be wondering about the young boy who helped me so much in my learning, that I referred to here? He did very well in therapy and was able to process his trauma. However, I'm keenly aware that there is much that I would now do differently, armed with a much fuller therapeutic toolbox. This learning

only comes with the experience of bearing witness to the child's trauma and pain in the therapy room. As trauma therapists, we cannot be the bystander who does nothing, rather we need to "act, engage and remember', (Herman 1992), and most of all, commit to being brave enough to not 'turn away'.

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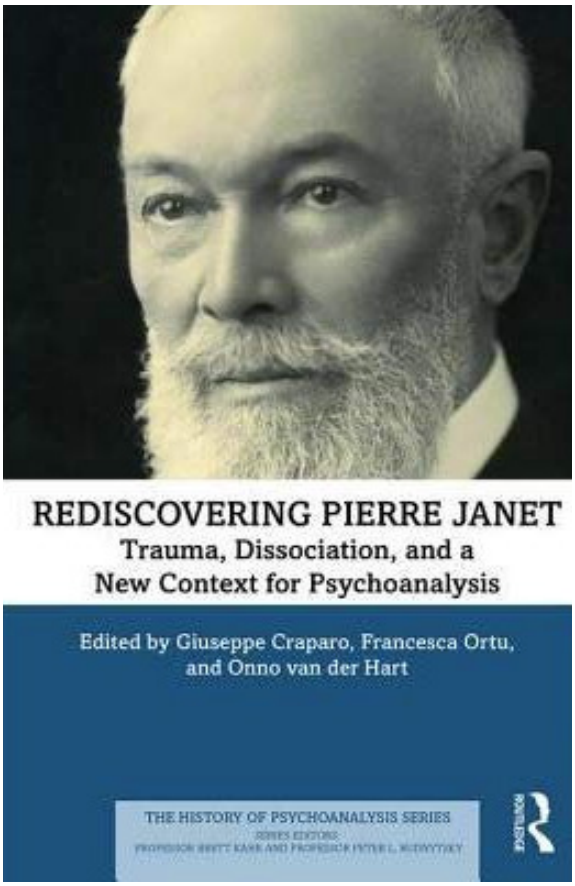
Book review by: Sharon Korman

Rediscovering Pierre Janet: Trauma, Dissociation, and a New Context for Psychoanalysis

Editors: Giuseppe Craparo, Francesca Ortu , & Onno van der Hart, 2019
Routledge, 270 pages ISBN: 978-0367193560



Previously to reading this recently released and cohesively edited book, my knowledge of Pierre Janet was rudimentary. I had come to my basic understandings through my trainings in both the Theory of Structural Dissociation of the Personality and Sensorimotor Psychotherapy. I resonated with the ideas as they had been presented to me, but admittedly my understanding of Janet's basic concepts lacked depth. I was curious to read and understand more about Janet and admit to have felt a tad bit intimidated by the title's stated psychoanalytic frame. My training base was Family Systems and I have come to psychoanalytic and psychodynamic thinking rather late in my career, so I feared becoming lost in terminology and conceptualization that I didn't fully understand. But as I read on, I was pleasantly surprised to realize that although I needed a dictionary close at hand to understand some psychiatric terms that were used, the book in fact is structured to build on Janet's concepts from a historical and developmental frame. The building blocks are laid and the threads of Janet's concepts were woven and rewoven throughout the book so that the chapters represent repetitive and overlapping perspectives that ultimately provide a layering and deepening of Janet's conceptual views and influences in our field since the end of the 19th century.

The distinguished list of international contributors is long and represents more than 9 countries when one includes not only their country of current practice but their training and international experience. The views of the contributors speak at once to different perspectives and influences of Janet, while at the same time bring together a unified and holistic understanding of him and his ideas.

Rediscovering begins with two chapters, which introduce Janet's fundamental ideas and continues on with three sections each focusing on a different aspect of understanding his widespread contribution to what are currently considered the gold standards of the conceptualization of the impact and treatment of traumatic experience both from an attachment/developmental perspective as well as a traumatic event perspective.

The first section focuses on Janet's influence at the time of the birth of psychoanalysis. The second section highlights his influence on contemporary psychotraumatology and the third focuses on Janet's major contributions and influences on current psychotherapy.

In the first chapter, Onno van der Hart and Barbara Friedman introduce us to Janet by placing him at the time in history when hysteria was a term that encompassed a spectrum of disorders, including what is now diagnosed as dissociation, somatization, conversion, borderline personality and post-traumatic stress disorders, and hypnosis was the treatment of choice. We are given a brief history of his life, commencing with his reputation as a stellar student with interests in both science and philosophy, throughout his academic, research and clinical career. Then we are presented with an in-depth summary of Janet's writings and central concepts.

We learn that Janet brought to his patients a keen ability to observe, track, document, and classify the symptomatic manifestations of what we now understand to be traumatic experience. He brought an unending curiosity and humanity to his work that offered respect and validation to his patients at a time when the truth of childhood abuse was dismissed to the realm of fantasy. He also offered a holistic body-based frame to understanding both symptoms and treatment goals, that has been proven out, with the newer research methodologies, in the neurobiological understanding of attachment, development and the impact of trauma on our bodies and our minds.

It is Janet who first coined the term "subconscious" (in contrast to Freud's concept of the unconscious), believing it to be representative of a narrowing of the field of consciousness. According to Janet, this along with dissociation were the two basic characteristics of hysteria.
He developed a theoretical model that included the concepts of psychological force and tension and a fundamental five-tier hierarchy of psychological functioning. His concept of psychological force refers to the amount of basic psychic energy available to an individual. Psychological tension refers to the ability to utilize one's psychological force. He called the highest level of psychological functioning "the reality function". By this, he meant the ability to perceive current reality with self-awareness of thoughts and feelings coupled with an ability to synthesize all of this internally and be able to act in an efficient, intentional, and integrated manner.

Habitual/automatic actions, fantasy and daydreaming, emotional reactions and useless muscular movements were the other four levels of mental functioning in descending order. Janet understood symptomology as resultant of a reduction in psychological tension and force, with a substitution of inferior less integrated mental operations for more synthesized and efficient functioning.

Chapter two (Francesca Ortu and Giuseppe Craparo) goes on to provide an in-depth analysis of Janet's fundamental concept of the subconscious and describes two phases to the development of his thinking. Between 1886 and 1916, Janet conceptualized a "psychology of dissociation" that emphasizes a dissociative vs repressed formulation in response to traumatic experiences. In Janet's view, the body and mind should be considered holistically. He believed that automatic phenomena (physical actions such as tics or other somatic symptoms or mental actions such as phobias or compulsive thoughts) were evidence of a lowered psychological synthesis (that is, psychological tension) and a narrowed field of consciousness resulting in "fixed ideas" that were repetitive in nature and inefficient. He saw this as a break in the normal balance between the mental tasks of creative synthesis of taking in and adjusting to new information and repetitive, automatic actions that can activate old learning that although appropriate in a past moment are no longer helpful in the present moment. This break in the normal balance was understood as the body/mind system having been overwhelmed with the psychological and physiological impact of the trauma, whether

relational or event driven or some combination of both.

This break of balance was seen as dissociative in nature, a passive absence of synthesis due to lowered psychological energy versus a "known" but actively repressed awareness as Freud described. Janet believed that visible body actions were a fundamental phenomenon with thought as an "interior duplication" of these action systems. Consciousness implied the ability for verbal expression of an integrated experience of self. "Fixed ideas" (thoughts or actions) evidenced as these activated action systems that were below consciousness or subconscious hence obvious and observable but automatic and out of the conscious control of the individual caught in the suffering of these repetitive symptoms.

From 1917 to 1947, the phase of the psychology of conduct, Janet came to modify his understanding of the subconscious. He understood consciousness as relative, the "effect of bringing into awareness" that which was not attended to consciously. He saw action such as bodily reflex as fundamental, with thought and consciousness as a higher level of this basic action and he understood this from an evolutionary perspective.

Part 1 (chapters 3–6), entitled: "Janet's Influence on psychoanalysis," begins with a chapter by Gabriele Cassullo that is a fascinating account of the life-long rivalry between Freud and Janet placed within the historical naissance of "the talking cure" and Freud's fundamental thinking. It evidences how Freud not only borrowed Janet's concepts, integrating them into his own theorizing without directly crediting Janet, but then also went on to actively discredit Janet's concepts in his own writing and lectures. Further along in the book, chapter 7 authored by Giovanni and Marianna Liotti, is an interesting companion to this historical perspective as it reflects on the comparison of Janet's ideas about a dissociative response to psychological trauma with the psychoanalytic theory of defense mechanisms. This reflection is presented to emphasize the authors' beliefs of the relevance of Janet's ideas for contemporary psychotraumatology. It invites the reader to further deepen their understanding of Janet's theories as seen through the lens of the newer research in the neurobiology of a traumatic response.

Chapter 4 highlights the influence that Janet had on Jung's theory of psychology. Jung, in contrast to Freud, openly noted his respect for Janet's concepts. Caterina Vezzoli delineates her belief that Jung's theories of self and psychological complexes were influenced by Janet's thinking and his differentiating from Freud's theory of sexual drives.

Chapters 5 (Gabriele Cassullo) and 6 (Clara Mucci, Giuseppe Craparo, and Vittorio Lingiardi) focus on Janet's influence on Object relations theory and ultimately the more recent shift of psychoanalytic thinking towards a relational intersubjective framing.

It is these rich chapters in particular that both challenged me and demanded a diligent re-reading as they combine a historical perspective with a Janetian influence on the development of psychoanalytic conceptualization as seen through a lens of understanding dissociative processes.

In combination with chapters 7–10 (7 Giovanni and Marianna Liotti, 8 & 9 Russell Meares and Cécile Barral, 10 Andrew Moskowitz, Gerhard Heim, Isabelle Saillot, and Vanessa Beavan), all of which focus on Janet's influence on contemporary psychotraumatology, the reader is led into current thinking about trauma, inclusive of neuroscience with a reweaving of the concepts that had already been placed within both a historical and developmental framework.

Of particular note is the attention given to Janet's understanding of quantifying of mental energy and how it shifts dynamically within all individuals including a whole chapter dedicated to how this reflects on the understanding of psychotic symptomology.

On page 118, Meares and Barral describe Janet in stating: "He was advocating a paradigm shift from

the idea of symptoms and illnesses as clear-cut categorical illnesses to a new understanding of syndromes as complex and constantly shifting self-states, thereby confirming the idea of the mind/self as both structure and process."
Janet is clearly shown to be a visionary in his ability to observe and conceptualize the human mind in both health and suffering.

Chapters 11–14 (11 Kathy Steele and Onno van der Hart,
12 Onno van der Hart, Paul Brown, and Bessel A. van der Kolk,
13 Gerhard Heim and Karl-Ernst Bühler, 14 Pat Ogden) of Part 3, "Janet's influence on current psychotherapy," underscores Janet's understanding of relational attachment and dependency needs, and transferences that arise in the treatment of trauma, his conceptual frame that treating trauma is multiphasic and treatment issues relative to both PTSD and other dissociative disorders that have held up for over a century!

What is particularly striking to me about this set of chapters is learning more about the intricacies of Janet's astute observations and formulations of his patients in understanding treatment issues
before there was any established frame of treatment or true compassion for the mentally ill. His work with the "hysterics" of Hôpital Salpêtrière through the working lens of hypnosis as the then treatment of choice led to a visionary understanding of the relational dynamics of traumatic attachment. Janet understood that in a traumatized individual there is both an intolerance of aloneness and a deeply imbedded fear of attachment, setting up strong emotions within the therapeutic relationship. He aptly viewed the hypnotic relationship as an attachment relationship versus seeing the vehement emotions that emerged in response to the therapist as resultant of hypnosis in particular. His comprehension of a multi-phasic approach and the importance of the stabilization of symptoms prior to the treatment of traumatic memories conceptualized through his ideas about mental energy, tension and force again highlight his ability to understand concepts that are now considered fundamental for any student of trauma treatment. Chapter 13 (Heim & Bühler) discusses in detail Janet's hypothesis of a diathesis-stress model of understanding the etiology of dissociative disorders, in which an individual with an innate vulnerability to a traumatic event becomes exhausted by their vehement emotions, reducing their psychological synthesis. This then leads to the formation of "fixed ideas" which further a negative feedback loop of continued lowered psychological tension and force and decreased cohesion of personality.

The final chapter of this section written by Pat Ogden who interprets Janet's understanding of the importance to include the body in trauma treatment as seen through the contemporary lens of Sensorimotor Psychotherapy.

The book closes with an epilogue entitled: "Dissociation in the DSM-V: Your view, S'il vous plait, Docteur Janet?". Written by Ellert
Nijenhuis, it was for me the pièce de résistance of this full-bodied book, as it brings Pierre Janet's voice into present time in a brilliantly entertaining monologue in which he channels Janet speaking to the authors of the current DSM's section on dissociative disorders giving his impressions and critical feedback. It was easy to imagine Janet as the passionate and brilliant observer, thinker and teacher that he was consistently throughout his long career and brought the book to a close in a full-circle fashion.

Rediscovering Pierre Janet is a rich rendering of the ideas of a great observer and thinker. I found some chapters more difficult to read than others, demanding to be re-read and studied.
The ancient parable of the blind men and the elephant kept playing in my mind as I digested this work. In this parable, a group of blind men encounter an elephant, each exploring a part of the elephant's body by touch and then describing their perceptions to the other men until a whole elephant could be conceptualized. There are multiple interpretations of this parable. In some versions the blind men are in conflict regarding their more limited subjective

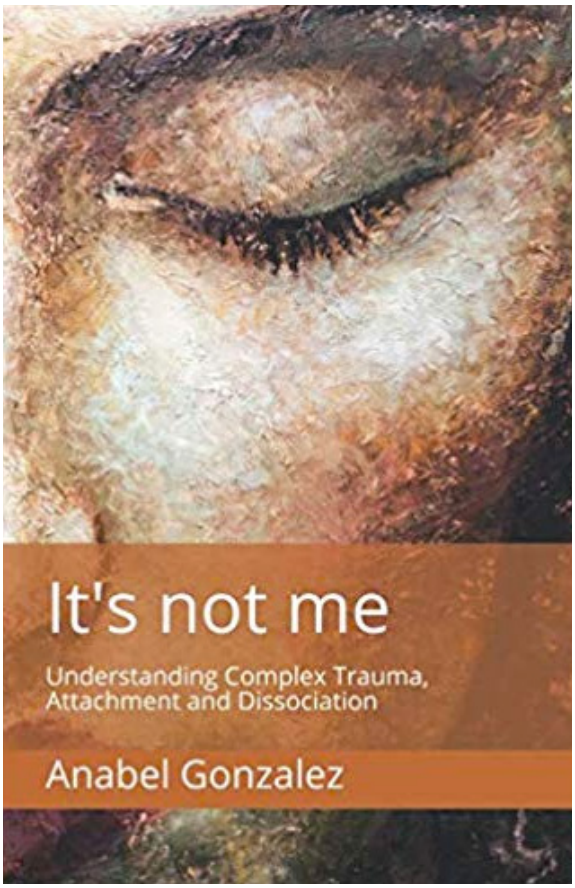
yet personally truthful experience of reality and are unable to come up with a united shared truth. In other versions the men come together to create a cohesive reality born of their intersubjective truth.

I think Janet would be pleased that the whole elephant is finally coming into view.

Book review by: Tayeba Jaleel

It's not me: Understanding Complex Trauma, Attachment and Dissociation

Author: Anabel Gonzalez (2018), Translators Beatriz Morales and Brandon Lane Ferguson Anabel Gonzalez, 210 pages, ISNB: 978-84-09-06686-05/ISBN: 978-84-09-01361-6



This gem of a book by Anabel Gonzalez is based on her work over many years as a psychiatrist and psychotherapist. The subject of complex trauma, attachment and dissociation is well illustrated using a warm and compassionate approach. She gives a number of detailed and undisguised accounts of her work with patients that are fascinating and frequently moving and painful. These illustrate complicated learning points about process and theory as well as provoking thought and feeling. This book is comprehensive and should not deter readers from reading the short, excellent introduction and then those parts that interest them.

This book opens with an overview of the topic, looking at the early complex trauma and insecure attachment bonds and the concept of dissociation. It offers insight as to why adverse childhood experiences manifest themselves and why these manifestations persist. She urges reflection upon childhood experiences with caregivers to develop an understanding of difficulties in present relationships. She poignantly writes, "We must learn to look at ourselves with new eyes... If we can understand, we can begin to change" (p.7), illustrating the process of recovery.

Chapter by chapter, the author constructs an insightful description of the interplay between internal and external emotional worlds. She gives a stimulating and moving vignette of John, a soldier with 'emotional numbness'. In doing so, she explores the characteristics of the human mind and instinctive defensive systems and reminds us of the pitfalls of not reconnecting to buried emotions. The reader is then offered a deeper understanding of the significance of moving from automatic survival systems to manual survival systems.

In the next chapter there is a useful description of emotions and feelings and their main functions. This section has the value of being a psycho-educational tool for our clients. For example, when discussing rage, the author describes in simple terms how this emotion can become "stuck inside" and often "become a symptom of different disorders" (p.17), commenting on the process of letting go.

There is a strong chapter on the importance of reviewing memories of the past so that old and unprocessed experiences do not continue to influence and interfere with the present. The author brings together knowledge about how traumatic memories are stored separately from regular memories, such that they cannot link with memory networks that have more adaptive information. In addition, new information, or positive experiences, cannot connect with the disturbing memory, as it is now in its own memory network, separate from the adaptive memory networks. This means that when the traumatic memory is accessed, it is without an ability to resolve the disturbance caused. The author then discusses the brain's innate healing tendency and that if we slowly, gently and mindfully face our past, the separately stored trauma memory is eventually able to link with positive memory networks, discharging the disturbance surrounding the original experiences.

The tender subject of triggers and the sequences of emotional states is discussed in the next chapter. This is followed by an overview of the importance of listening to our body. The author beautifully illustrates how sitting with our emotions and the discomfort of doing so can help us to understand our internal processes. She explores the link between psychological problems and physical illnesses, and offers a few simple ideas of how to connect with our body with a view to "learning to tolerate our feelings and thinking of them with the attitude of a caregiver, instead of avoiding them or suppressing them emotionally" (p.50).

Chapters seven and eight cover attachment systems and how we can deepen our understanding of emotional regulation. This is followed by an overview of how we speak with ourselves. The author makes the link between internal discourse and the regulation of our emotional states. The text is concise and active in the way it seeks to engage the reader.

There are major sections on the different parts of ourselves and the author stresses the importance of looking at these parts with a new lens, with a view to understanding, acceptance and integration. She writes a thought-provoking piece on blocked fight and flight responses and the need for survival and protective responses. The rich descriptions offer a wonderful learning opportunity for those with professional interest and riveting reading for the more general reader.

There follows an interesting discussion about extreme trauma and how this overwhelms the mind, creating splits. The author remarks how "[p]utting these parts together again is part of the recovery process" (p.71), placing high importance on inner child work. Here, she identifies the process of allowing fragmented parts to bond with healthier parts.

The two chapters appropriately placed at the centre of the book are concerned with the importance of recovery built from the ability to show vulnerability and taking appropriate responsibility. The author highlights different defensive responses and poses five key questions, which if used with clients have the ability to facilitate both an understanding and a responsibility:

1) What am I protecting myself from?

2) Where did I learn to protect myself this way?

3) Is this really protecting me now?

4) What would help me better in this situation?

5) What is the usefulness of the system that I'm using, where is its place, and how can it be repurposed? (p.98)

The latter part of the book focuses on relearning patterns of beliefs, emotions and behaviour. This is discussed in a very clear, helpful and approachable fashion. It concludes with vivid metaphors, a discussion of our internal world fitting better and more appropriate for the time we are living in. The author devotes considerable time to explaining the importance of integrating our history and constructing a new narrative of our life, with

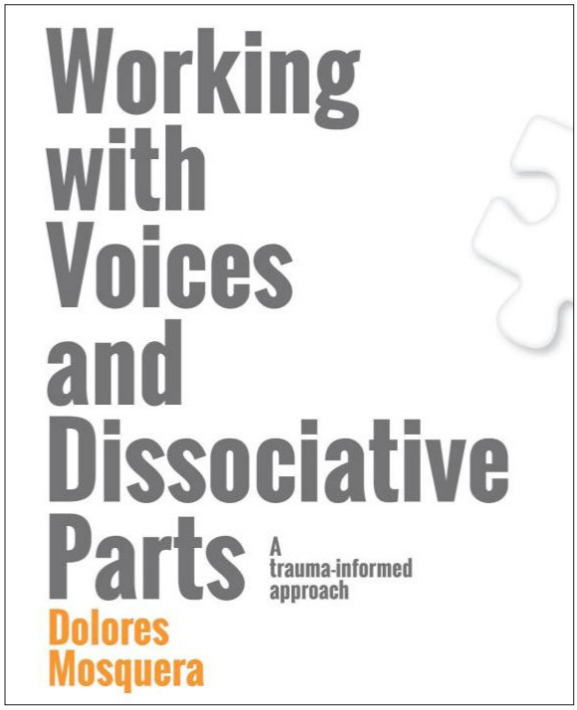
a certain emotional distance. She writes with authority and considerable understanding, and takes the reader on a guided tour of emotions in a lively and affirming way.

In summary, Anabel Gonzalez provides a rich store of material, which comes from her talent to explain and make things of great complexity clear in simple, straightforward language. This book is a gift. Published at a time when the concept of dissociation is becoming more widely accepted and recognised, the author's contribution to theory and practice will be warmly welcomed nationally and internationally.

Book review by: Valerie Sinason

Working with Voices and Dissociative Parts: A trauma informed Approach

Author: Dolores Mosquera Institute for the Treatment of Trauma and Personality Disorders, INTRA-TP, Spain



This large and well laid-out workbook (over 400 pages) by an international specialist in the field, is an inspirational aid to all clinicians in our field. It is divided into five parts, key concepts, basic interventions, work with challenging parts, co-consciousness and integration. It includes EMDR as well as other psychotherapeutic ideas and provides helpful definitions of the different models.

The tone is collaborative throughout and in invoking different ideas from different therapeutic models, Mosquera offers a model of professional co-consciousness which is an antidote to partisanship! Her caveats and aids are pragmatic and generously written and manage a teaching tone throughout the book of humble but confident enabler rather than an authoritarian stance. In this way the layout, chapters and division into five parts all organically join to empower the reader.

The book helps the absolute beginner and the senior consultant. As a psychoanalyst I was riveted to see concepts dear to me expressed in such clear jargon-free language.

The book is thorough and covers structures of a session, and relational growth as well as understanding the role of perpetrator parts, of self-injury, of switching, of high risk behaviour is dealt with calmly and compassionately. There is even a summary of the parts of the book at the end as an aide memoire.

Dolores Mosquera succeeds in bringing her clinical wisdom to life. This is a must for the clinician's library.

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!

Preliminary Evidence of a Missing Self Bias in Face Perception for Individuals with Dissociative Identity Disorder.

Lebois, L. A., Wolff, J. D., Hill, S. B., Bigony, C. E., Winternitz, S., Ressler, K. J., & Kaufman, M. L.

Failing to recognize one's mirror image can signal an abnormality in one's sense of self. In dissociative identity disorder (DID), individuals often report that their mirror image can feel unfamiliar or distorted. They also experience some of their own thoughts, emotions, and bodily sensations as if they are nonautobiographical and sometimes as if instead, they belong to someone else. To assess these experiences, we designed a novel backwards masking paradigm in which participants were covertly shown their own face, masked by a stranger's face. Participants rated feelings of familiarity associated with the strangers' faces. 21 control participants without trauma-generated dissociation rated masks, which were covertly preceded by their own face, as more familiar compared to masks preceded by a stranger's face. In contrast, across two samples, 28 individuals with DID and similar clinical presentations (DSM-IV Dissociative Disorder Not Otherwise Specified type 1) did not show increased familiarity ratings to their own masked face. However, their familiarity ratings interacted with self-reported identity state integration. Individuals with higher levels of identity state integration had response patterns similar to control participants. These data provide empirical evidence of aberrant self-referential processing in DID/DDNOS and suggest this is restored with identity state integration.

Lebois, L. A., Wolff, J. D., Hill, S. B., Bigony, C. E., Winternitz, S., Ressler, K. J., & Kaufman, M. L. (2019). Preliminary Evidence of a Missing Self Bias in Face Perception for Individuals with Dissociative Identity Disorder. Journal of Trauma & Dissociation, 20(2), 140-164. [retrieved 08/10/2019]: https://www.tandfonline.com/doi/abs/10.1080/15299732.2018.1547807

Dissociative identity disorder: validity and use in the criminal justice system

Paris, J.

This review examines whether the diagnosis of dissociative identity disorder (DID) could be used to support a defence of 'not guilty by reason of insanity' (NGRI, or the insanity defence). The problem is that DID has doubtful validity and can easily be malingered. However, the diagnosis is listed in standard psychiatric manuals. If accepted as valid, DID would have problematic forensic implications.

Paris, J. (2019). Dissociative identity disorder: validity and use in the criminal justice system. BJPsych Advances, 25(5), 287-293. [retrieved 08/10/2019]: https://www.cambridge.org/core/journals/bjpsych-advances/article/dissociative-identity-disorder-validity-and-use-in-the-criminal-justice-system/C1C27EE9731782570E1376A3EDA48CE4

Attachment style moderates effects of FKBP5 polymorphisms and childhood abuse on post-traumatic stress symptoms: Results from the National Health and Resilience in Veterans Study

Tamman, A. J., Sippel, L. M., Han, S., Neria, Y., Krystal, J. H., Southwick, S. M., ... & Pietrzak, R. H.

Objectives: To determine the main and interactive effects of four FKBP5 polymorphisms (rs9296158, rs3800373, rs1360780 and rs9470080), childhood abuse and attachment style in predicting severity of PTSD symptoms in two independent, nationally representative samples of US military veterans.
Methods: Data were analysed from two independent samples of European-American US military veterans who participated in the National Health and Resilience in Veterans Study (N=1,585 and 577 respectively).
Results: Results revealed that carriage of two FKBP5 minor alleles, childhood abuse and insecure attachment style were associated with greater severity of PTSD symptoms. Gene×environment interactions were also observed, with the interaction of FKBP5 homozygous minor allele carriage and history of childhood abuse associated with greater severity of PTSD symptoms; however, these effects were fully counteracted by secure attachment style.
Conclusions: Results of this study build on prior work demonstrating a gene×environment interaction between FKBP5 polymorphisms and childhood abuse in predicting risk for PTSD by suggesting that attachment style may moderate this effect. This study has implications for prevention and treatment efforts designed to promote a secure attachment style in veterans with high-risk FKBP5 genotypes and childhood abuse histories.

Tamman, A. J., Sippel, L. M., Han, S., Neria, Y., Krystal, J. H., Southwick, S. M., ... & Pietrzak, R. H. (2019). Attachment style moderates effects of FKBP5 polymorphisms and childhood abuse on post-traumatic stress symptoms: Results from the National Health and Resilience in Veterans Study. The World Journal of Biological Psychiatry, 20(4), 289-300. [retrieved 08/10/2019]: https://www.tandfonline.com/doi/abs/10.1080/15622975.2017.1376114

The contribution of ADHD and attachment difficulties to online pornography use among students

Niazof, D., Weizman, A., & Weinstein, A.

Background
There is a high rate of ADHD among individuals with compulsive sexual behavior disorder (CSBD). There is also evidence for an association between compulsive sexual behavior disorder, sensation seeking and attachment difficulties. Problematic pornography use may be considered as a subtype of CSBD hence it merits investigation. The aim of the current study was to investigate the relationships between ADHD, attachment style, sensation seeking and problematic use of pornography online in the general population.

Methods
The sample was comprised of 85 participants [38 men (44.7%) and 47 women (55.3%)] with mean age 25. 66 (SD = 4.63) and 26.42 (SD = 6.94) years, respectively. There were 30 participants (35%) with ADHD and 55 participants (65%) without ADHD. They were recruited on-line via social network sites. They filled in a demographic questionnaire, Zukerman's Sensation Seeking Scale, Experience in Close Relationship (ECR) questionnaire that assessed anxious and avoidant attachment and the Cyber Pornography Use Inventory (CPUI).

Results
Individuals with self-reported ADHD had higher scores of avoidant attachment on the ECR and CPUI compared with individuals without ADHD. Multivariate linear regression analysis has indicated that male gender, ADHD and anxious attachment on the ECR contributed significantly to the variance of cyber pornography use, and explained 34% of the variance.

Conclusions
The results indicate that males with ADHD and anxious attachment show an extensive use of pornography online. Males with ADHD who have difficulties in close relationship may use online pornography excessively that in turn may exacerbate their difficulty in forming secure attachment at adult life, a finding that has major clinical implications.

Niazof, D., Weizman, A., & Weinstein, A. (2019). The contribution of ADHD and attachment difficulties to online pornography use among students. Comprehensive psychiatry. [retrieved 08/10/2019]: https://www.sciencedirect.com/science/article/pii/S0010440X1930032X

Adverse childhood experiences, epigenetics and telomere length variation in childhood and beyond: a systematic review of the literature

Lang, J., McKie, J., Smith, H., McLaughlin, A., Gillberg, C., Shiels, P. G., & Minnis, H.

A systematic review following PRISMA guidelines was conducted to answer the question: What epigenetic, telomeric and associated biological changes are associated with exposure to adverse childhood experiences (ACEs) in the under 12s? Using PRISMA guidelines, appropriate databases were searched. 190 papers were returned with 38 articles fully reviewed. Articles were each independently quality rated by two authors using the Crowe Critical Appraisal Tool and data were extracted. Of the 38 articles, 23 were rated as very high quality. Most study participants were adults (n=7769) with n=727 child participants. Only seven of the very/high-quality studies were prospective and involved children. Methylation was the most studied method of epigenetic modification. There is some evidence supporting epigenetic modification of certain markers in participants exposed to ACEs measured in adulthood. Research is lacking on non-coding aspects of the epigenome and on coding aspects other than DNA methylation. There is some evidence of a more powerful effect on telomere length if physical neglect was involved. Much further work is required to model biological and psychological effects of epigenetic changes during childhood using prospective study designs. The effect of ACEs on the cellular ageing process during childhood is inadequately investigated and relies solely on measure of telomere length. Future research suggestions are proposed.

Lang, J., McKie, J., Smith, H., McLaughlin, A., Gillberg, C., Shiels, P. G., & Minnis, H. (2019). Adverse childhood experiences, epigenetics and telomere length variation in childhood and beyond: a systematic review of the literature. European child & adolescent psychiatry, 1-10. [retrieved 08/10/2019]: https://link.springer.com/article/10.1007/s00787-019-01329-1

Investigating patterns of neural response associated with childhood abuse v. childhood neglect

Puetz, V. B., Viding, E., Gerin, M. I., Pingault, J. B., Sethi, A., Knodt, A. R., ... & McCrory, E.

Background
Childhood maltreatment is robustly associated with increased risk of poor mental health outcome and changes in brain function. The authors investigated whether childhood experience of abuse (e.g. physical, emotional and sexual abuse) and neglect (physical and emotional deprivation) was differentially associated with neural reactivity to threat.

Methods
Participants were drawn from an existing study and allocated to one of four groups based on self-report of childhood maltreatment experience: individuals with childhood abuse experiences (n = 70); individuals with childhood neglect experiences (n = 87); individuals with combined experience of childhood abuse and neglect (n = 50); and non-maltreated individuals (n = 207) propensity score matched (PSM) on gender, age, IQ, psychopathology and SES. Neural reactivity to facial cues signalling threat was compared across groups, allowing the differential effects associated with particular forms of maltreatment experience to be isolated.

Results
Brain imaging analyses indicated that while childhood abuse was associated with heightened localised threat reactivity in ventral amygdala, experiences of neglect were associated with heightened reactivity in a distributed cortical fronto-parietal network supporting complex social and cognitive processing as well as in the dorsal amygdala. Unexpectedly, combined experiences of abuse and neglect were associated with hypo-activation in several higher-order cortical regions as well as the amygdala.

Conclusions
Different forms of childhood maltreatment exert differential effects in neural threat reactivity: while the effects of abuse are more focal, the effects of neglect and combined experiences of abuse are more distributed. These findings are relevant for understanding the range of psychiatric outcomes following childhood maltreatment and have implications for intervention.

Puetz, V. B., Viding, E., Gerin, M. I., Pingault, J. B., Sethi, A., Knodt, A. R., ... & McCrory, E. (2019). Investigating patterns of neural response associated with childhood abuse v. childhood neglect. Psychological medicine, 1-10. [retrieved 08/10/2019]: https://www.cambridge.org/core/journals/psychological-medicine/article/investigating-patterns-of-neural-response-associated-with-childhood-abuse-v-childhood-neglect/28112BC919FAC1DF89BD8B424F83860E

Perinatal promotive and protective factors for women with histories of childhood abuse and neglect

Atzl, V. M., Grande, L. A., Davis, E. P., & Narayan, A. J.

Background
Integrative research summarizing promotive and protective factors that reduce the effects of childhood abuse and neglect on pregnant women and their babies' healthy functioning is needed.

Objective
This narrative systematic review synthesized the quantitative literature on protective and promotive factors that support maternal mental health and maternal-infant bonding among women exposed to childhood adversity, including childhood abuse and neglect.

Methods
Using a comprehensive list of key terms related to the perinatal period, childhood adversity, and protective/promotive factors, 8423 non-duplicated articles were identified through database searches in PsychInfo and Web of Science, and references in retrieved articles. Thirty-seven full text articles were inspected; of those 18 were included.

Results
Protective and promotive factors fell into three categories: a) women's internal capacities (e.g., self-esteem, coping ability), b) external early resources (e.g., positive childhood experiences) and c) external contemporaneous resources (e.g., social support). Although all three categories were associated with more resilient outcomes, external contemporaneous factors, and specifically, social support, were the most commonly-studied protective and/or promotive factor. Social support from family and romantic partners during the perinatal period was particularly protective for women with histories of childhood abuse and neglect and was examined across several dimensions of support and contexts.

Conclusions
The presence of women's internal capacities, and external early and contemporaneous resources help to foster more positive outcomes during the perinatal period for women with histories of childhood adversity. Future research should study co-occurring multilevel promotive and protective factors to inform how they integratively deter the intergenerational transmission of risk.

Atzl, V. M., Grande, L. A., Davis, E. P., & Narayan, A. J. (2019). Perinatal promotive and protective factors for women with histories of childhood abuse and neglect. Child abuse & neglect, 91, 63-77. [retrieved 08/10/2019]: https://www.sciencedirect.com/science/article/abs/pii/S0145213419300651

The Meaning of Risk in Reproductive Decisions after Childhood Abuse and Neglect

Matthews, E. J., & Desjardins, M.

Few studies have addressed the experiences and meaning of family formation among adults who have experienced childhood maltreatment. From a critical interpretivist approach, we explored women's and men's perceptions of the risk of intergenerational transmission of family dysfunction in their stories of reproductive decisions. In this qualitative study, transcripts from interviews with 15 adults who self-reported childhood physical abuse, emotional abuse, neglect, or exposure to family violence were coded, thematically analysed, and patterns of meaning interpreted. In their reflections on their childhood experiences and the meaning of family formation in the present, risk was constructed in three ways: seven women who described themselves as meant to be mothers would not pass on dysfunction but rather a good family life; four women who described themselves as not meant to be mothers (voluntarily childless or parent allies) eliminated any risk of transmission of dysfunction; and two men and two women were uncertain about starting families and of their ability to eliminate the transfer of dysfunction. The findings offer an introduction to such adults' generative experiences, point to future research questions, and afford understanding for mental health professionals who can provide anticipatory guidance during the transition to parenthood for adults who have experienced childhood maltreatment.

Matthews, E. J., & Desjardins, M. (2019). The Meaning of Risk in Reproductive Decisions after Childhood Abuse and Neglect. Journal of Family Violence, 1-10. [retrieved 08/10/2019]: https://link.springer.com/article/10.1007/s10896-019-00062-2

Psychometric liability to psychosis and childhood adversities are associated with shorter telomere length: A study on schizophrenia patients, unaffected siblings, and non-clinical controls

Çevik, B., Mançe-Çalışır, Ö., Atbaşoğlu, E. C., Saka, M. C., Alptekin, K., Üçok, A., ... & Gümüş-Akay, G.

Compared to the general population, individuals diagnosed with Schizophrenia (SCZ) experience a higher frequency and an earlier onset of chronic medical disorders, resulting in a reduction in life expectancy by an average of 15–25 years. Recently, it has been hypothesized that SCZ is a syndrome of accelerated aging. Childhood adversity was also associated with the pathogenesis and course of SCZ. Our hypothesis was that both SCZ patients and their unaffected siblings would have shorter telomere length (TL) compared to of non-clinical controls. Our additional goals were to determine (1) whether shorter TL correlates with intermediate phenotypes of SCZ (i.e. Psychosis-like symptoms and schizotypal traits); and (2) whether childhood adversities have a moderating role in TL shortening among SCZ and their unaffected siblings. To this end, SCZ patients (n = 100), their unaffected siblings (n = 100) and non-clinical controls (n = 100) were enrolled. The main variables were TL, measured by aTL-qPCR; psychotic-like and schizotypal symptoms, assessed by The Community Assessment of Psychic Experience (CAPE) and the Structured Interview for Schizotypy-Revised (SIS-R), respectively; and childhood adversities evaluated by the Childhood Experience of Care and Abuse (CECA)-Interview. Potentially relevant variables also included in the analyses were: Global Assessment of Functioning (GAF) scores, cognitive performance, and socio-demographic features. In contrast to our hypothesis patients had similar TL when compared to the non-clinical controls. Interestingly, unaffected siblings had longer TL compared to both patients and controls ($p < 0.001$). Independent from group status a negative correlation was observed between TL and psychotic-like symptoms as rated by the CAPE ($p < 0.01$). Childhood adversities, especially lonelinessbetween ages 0 and 11 were also negatively associated with TL ($p < 0.05$). Our findings suggest that psychometric liability to psychosis and childhood adversities may be associated with shorter TL. Unaffected siblings had longer TL, suggesting the potential role of resilience on both the TL and the clinical presentation. These findings must be considered preliminary, calling for larger-scale replication efforts.

Çevik, B., Mançe-Çalışır, Ö., Atbaşoğlu, E. C., Saka, M. C., Alptekin, K., Üçok, A., ... & Gümüş-Akay, G. (2019). Psychometric liability to psychosis and childhood adversities are associated with shorter telomere length: A study on schizophrenia patients, unaffected siblings, and non-clinical controls. Journal of psychiatric research, 111, 169-185. [retrieved 08/10/2019]: https://www.sciencedirect.com/science/article/abs/pii/S0022395618310628

Examining perceived stress, childhood trauma and interpersonal trauma in individuals with drug addiction

Garami, J., Valikhani, A., Parkes, D., Haber, P., Mahlberg, J., Misiak, B., ... & Moustafa, A. A.

The investigation of psychosocial factors in relation to opiate addiction is limited and typically uses binary measures to assess how incidences of childhood trauma correlate with addiction. There has also been a lack of enquiry into how experiences of noninterpersonal versus interpersonal trauma may impact drug use addiction. In this regard, the current study utilized a novel measurement of interpersonal versus noninterpersonal lifetime trauma and a scale assessing severity of childhood trauma to examine how these factors may impact patients with opioid addiction. The interaction between these factors and current perceived stress was also examined. Thirty-six opioid-dependent individuals (recruited from the Drug Health Services and Opioid Treatment Program at the Royal Prince Alfred Hospital in Sydney, Australia) and 33 healthy controls completed the Childhood Maltreatment Questionnaire, Lifetime Trauma Survey, and Perceived Levels of Stress Scale. The patient group reported significantly greater childhood trauma severity, more incidences of lifetime trauma, and higher perceived stress than controls. Logistic regression analyses indicated that the severity of childhood trauma was more strongly associated with addiction status than perceived stress. A greater number of lifetime trauma incidence was the best predictor of addiction. Contrary to expectations, noninterpersonal lifetime trauma was a better predictor of addiction status than was interpersonal lifetime trauma. Results suggest that lifetime trauma and childhood trauma may play an important factor in opioid addiction over what can be accounted for by stress.

Garami, J., Valikhani, A., Parkes, D., Haber, P., Mahlberg, J., Misiak, B., ... & Moustafa, A. A. (2019). Examining perceived stress, childhood trauma and interpersonal trauma in individuals with drug addiction. Psychological reports, 122(2), 433-450.[retrieved 08/10/2019]: https://journals.sagepub.com/doi/abs/10.1177/0033294118764918

Hippocampal volume modulates salivary oxytocin level increases after intranasal oxytocin administration

Riem, M. M., Van IJzendoorn, M. H., & Bakermans-Kranenburg, M. J.

Adverse childhood experiences have been shown to affect sensitivity to intranasal oxytocin administration, but the neural mechanisms underlying this altered sensitivity are unclear. The aim of the current study was to examine whether hippocampal abnormalities underlie the effects of adversity on the response to oxytocin administration. In a sample of healthy women (N=54, age M=19.63), we examined 1) the association between hippocampal volume and experiences of emotional maltreatment and 2) whether hippocampal volume reductions influence the effect of intranasal oxytocin administration on salivary oxytocin levels. There was no association between hippocampal volume and experiences of emotional maltreatment in the current study. However, we found that larger hippocampal volume was related to a stronger increase in salivary oxytocin level after intranasal oxytocin administration. The hippocampus may be a neural substrate underlying individual differences in sensitivity to oxytocin administration.

Riem, M. M., Van Ijzendoorn, M. H., & Bakermans-Kranenburg, M. J. (2019). Hippocampal volume modulates salivary oxytocin level increases after intranasal oxytocin administration. Psychoneuroendocrinology, 101, 182-185. [retrieved 08/10/2019]: https://www.sciencedirect.com/science/article/pii/S0306453018309569

Can fMRI discriminate between deception and false memory? A meta-analytic comparison between deception and false memory studies

Yu, J., Tao, Q., Zhang, R., Chan, C. C., & Lee, T. M.

Previous research has highlighted the potential of fMRI in discriminating between truth and falsehood. However, falsehoods may not necessarily represent a deliberate intention to deceive; they can be a result of false memory too. It is important to show that fMRI can discriminate between deception and false memory, before it can be applied in legal contexts for deception detection. To this end, we performed a meta-analytic comparison of brain activation between deception and false memory. Activation likelihood estimation meta-analyses were conducted separately on 49 deception (61 contrasts; Ntotal = 991) and 28 false memory (32 contrasts; Ntotal = 484) studies. The contrasts obtained from these meta-analyses were entered into subsequent conjunction and contrast analyses. Deception and false memory tasks activated several frontoparietal regions. Both tasks activated the left superior frontal gyrus. Deception, relative to false memory, was associated with increased activation in the right superior temporal gyrus, right insula, left inferior parietal lobule and right superior frontal gyrus. These results provide some evidence to suggest that fMRI can discriminate between deception and false memory.

Yu, J., Tao, Q., Zhang, R., Chan, C. C., & Lee, T. M. (2019). Can fMRI discriminate between deception and false memory? A meta-analytic comparison between deception and false memory studies. Neuroscience & Biobehavioral Reviews. [retrieved 08/10/2019]: https://www.sciencedirect.com/science/article/pii/S0149763419301873

The Interactive Trauma Scale: a web-based measure for children with autism

Hoover, D. W., & Romero, E. M.

This study examined the feasibility, acceptability, and psychometric characteristics of a web-based touchscreen app prototype designed to assess self-reported trauma exposure and symptoms in children with autism spectrum disorder (ASD). The prototype was piloted with 20 clinically referred children previously diagnosed with ASD and having various known trauma exposures. User satisfaction and reported ease of use was high. The measure was sensitive to reports of teasing and bullying, endorsed by 75% and 70% of participants, respectively. Validity was assessed via comparisons with the UCLA Posttraumatic Stress Disorder Reaction Index and analysis of participants' trauma exposures and symptoms. Clinical implications are discussed including issues of trauma screening, diagnosis, and treatment planning for traumatized youth with ASD.

Hoover, D. W., & Romero, E. M. (2019). The Interactive Trauma Scale: a web-based measure for children with autism. Journal of autism and developmental disorders, 49(4), 1686-1692. [retrieved 08/10/2019]: https://link.springer.com/article/10.1007/s10803-018-03864-3

Moving beyond prison rape: Assessing sexual victimization among youth in custody

Ahlin, E. M.

This integrated literature review discusses the need to treat youth in custody distinctly from adult carceral populations when examining sexual victimization. Although the Prison Rape Elimination Act (PREA) mandates correctional facilities address sexual assault in both populations, the lack of available information on risk factors among youth may lead to practitioners and policy-makers becoming reliant on the adult literature when making decisions on preventative and reactive care for juveniles. Such extrapolation may lead to an inadequate or even inappropriate response for youth in custody. A research agenda using an ecological framework to determine youth-specific individual and structural level risk factors is proposed. Findings demonstrate differences in sexual victimization risk factors for adults in jails and prisons compared to youth in custody. This review serves as a foundation for moving research on this topic to juvenile custody settings while also acknowledging the challenges associated with conducting such research among youth in custody.

Ahlin, E. M. (2019). Moving beyond prison rape: Assessing sexual victimization among youth in custody. Aggression and Violent Behavior. [retrieved 08/10/2019]: https://www.sciencedirect.com/science/article/pii/S1359178918301460 06/05/2019]: https://www.tandfonline.com/doi/abs/10.1080/00332828.2019.1587975

DATES FOR YOUR DIARY IN 2019

27–29 September. 2019
National Conference of the Italian EMDR Association: Clinica, ricerca, interventi: 20 anni di terapia EMDR in Italia. In Italian. Rome, Italy.
https://emdr.it/index.php/congresso-nazionale-associazione-emdr-italia-27-29-settembre-milano-mico-congressi/

12 October 2019.
Workshop: Neurobiology and treatment of traumatic dissociation. With Frank Corrigan. In English with Italian translation. Also available as a webinar. Parma, Italy.
http://www.diegogiusti.com/corrigan2019

20 October 2019.
Workshop: Working with dissociative disorders: The strength of cooperation (Lavorare con i disturbi dissociativi: la forza della cooperazione). With Melanie Goodwin and Remy Aquarone. In English with Italian translation. Cagliari, Italy.
psicoterapiaricercatd@gmail.com

24–26 October 2019.
ESTD biannual congress: The Legacy of Trauma and Dissociation: Body and Mind in a New Perspective. Rome, Italy
http://www.estd.org

15–17 November 2019.
ISC Trauma and attachment conference: Relationships, consciousness and the developing self. With Marco Iacoboni, Orit Badouk Epstein, Bruce Ecker, Peter Fonagi, Stephen Porges, Alessandro Carmelita, Marina Cirio, Marilyn Glenville, Jane Hart, Ruth Lanius, Onno van der Hart, and Pat Ogden. London, UK.
https://uk.international-isc.com/negozio/workshop/london-2019-congress-attachment-trauma-relationships-consciousness-and-the-developing-self/

16–17 November 2019.
Workshop: Traumatic attachment and co-regulation: The neurobiology of relationship. With Janina Fisher. In English. Rome, Italy.
https://uk.international-isc.com/wp-content/uploads/2019/03/brochure-Fisher-2019-ROMA-eng-1.pdf

12–16 March 2020.
ISSTD World Congress on Complex Trauma and Dissociation: Envisioning the Coming Decade. San Francisco, USA.
https://annualconference.isst-d.org/

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

PLEASE LET US KNOW ABOUT FUTURE EVENTS IN YOUR COUNTRY!
Send the dates, title, location, speaker(s), language, website and contact information to jarydberg@gmail.com.

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