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# ESTD NEWSLETTER

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# QUARTERLY QUOTE

Janet (1919/25, p. 917)

## **Phobias as defensive reactions**

"Phobias are often defensive reactions through which the mind attempts to avoid exhaustion by inhibiting this or that action, either because it demands a great expenditure of energy or because it is wrongly considered a costly action."



Maria Paola Boldrini

ESTD president

## LETTER FROM THE PRESIDENT

Dear Colleagues and Fellow Members of ESTD,

I hope you had a relaxing summer and enjoyed time with your loved ones.

This first year of my presidency began with excellent work in the organization of webinars by the Scientific and Educational Committees. Many of you actively participated in our webinars with leading experts and young researchers, and we, as the Board, are grateful for your enthusiasm, which encourages us to continue organising these events. Among the webinars that received excellent feedback, I would like to mention the one with Judith Herman entitled "Truth and Repair: How Trauma Survivors Envision Justice," which was truly exciting, and one from Anabel Gonzalez and Sandra Baita entitled "Giving voice to neglect: from childhood through adulthood," - extremely stimulating for all clinicians. I would

like to remind you that the webinars are available in the members' area (<https://estd.org/webinars/>), one of the most important resources that ESTD offers its members.

Our society has a wealth of clinical and scientific experience, and educational events are multiplying in different countries. We are receiving an increasing number of requests for free patronage and dissemination of information from several Countries Representatives, but also from members who organise educational meetings. As the ESTD Board, we feel strongly about the importance of satisfying these requests. One of the aims of our association is to promote the diffusion of clinical and scientific knowledge in the field of Trauma and Dissociation. However, we also felt the need to be guarantors of the information we disseminate and of the free patronage of events, which is why we have established guidelines and an application form for submitting these requests. We invite you to consult the dedicated page and send us information about your initiatives: <https://estd.org/free-estd-patronage-and-promotion-of-educational-events/>.

The Annual General Meeting was held in June this year, and I would like to thank those who participated, hoping that next time there will be even more of us. During the meeting, we approved the 2024 financial statements, reviewed all the board's activities over the past year, and approved the rules for applying to be elected Board member. I invite you to consult the documents relating to the meeting on the ESTD website (<https://estd.org/agm/>). It is vital that, as members, you are informed about all aspects of the association and we as a Board need your contribution.

During the AGM, Lise Moeller's resignation as Board member was made official. As a Board, we would like to thank her once again for her years of tireless work in developing the activities of the Scientific Committee and being a valuable member of the Board.

This leads us to announce new elections for ESTD Board members will be held shortly. We will be following the current guidelines, as it is necessary to continue the work of the Board properly, also to ensure future turnover. You will receive news on this point soon.

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More webinars have been scheduled for the summer and fall; we look forward to seeing you there!  
In the end: the early registration to attend the Lisbon Conference in 2026 is now open ([https://estd2026.com/\\_homex.aspx](https://estd2026.com/_homex.aspx)). This will be the 10th ESTD congress, and will be the occasion to celebrate the 20th anniversary of our society's foundation. Don't miss it!

I invite you to check our website and social media to be informed about our activities. On behalf of the board, I send you our best wishes and I hope for you a peaceful season.

Warm regards.

Maria Paola Boldrini  
President, ESTD



# AS HORSES CAN BE THE WINDOWS TO THE HEART, CREATIVE APPROACHES ACCESS PLACES THAT WORDS CANNOT.

By: Marlene du Plessis

## Introduction

In the field of Equine-Assisted therapeutic interventions, the therapeutic process harnesses the intuitive and responsive nature of horses to facilitate emotional processing and access deep-seated experiences. Complementary to this approach, expressive modalities such as art, music, movement, and sand-based therapy

serve as alternative means of expression, particularly for individuals who find verbal communication challenging or insufficient. Engaging in creative practices enables individuals to explore and externalise complex emotions, allowing access to psychological dimensions that may not be easily articulated through language. Together, these two therapeutic approaches highlight the profound impact of both equine assisted interventions and creative modalities as mechanisms for

emotional exploration. They provide alternative pathways for healing that transcend the constraints of verbal communication, fostering deeper self-awareness and psychological integration.

Clients who have experienced trauma often navigate the world in a manner similar to horses in their natural environment. As prey animals, horses rely on hypervigilance for survival. Likewise, trauma survivors frequently perceive the world as a threatening place, where heightened alertness is a necessary mechanism for self-preservation.

In an equine-assisted setting, horses demonstrate a heightened sensitivity to authenticity, instinctively recognising when an individual is not fully present or genuine. This response is regulated by neuroception, the limbic system, and innate survival mechanisms.

In our trauma clients, the same mechanism is present. The vagus nerve (linked to the autonomic nervous system) plays a key role in neuroception (a term coined by Dr Stephen Porges), influencing heart rate, digestion and emotional regulation. The outcome is that clients often find it difficult to conceal their true emotional state or feign control in the presence of horses, as attempts to mask their struggles or project a sense of coping are readily perceived by the animals. Unlike human-to-human interactions, where social conventions may allow for emotional suppression or performative responses, horses respond only to what is genuinely communicated on an emotional and physiological level.

This became particularly prominent when I had to transition—albeit with initial reluctance—and leave my equine-assisted interventions in an outdoor setting for traditional therapeutic approaches in the indoor therapy room.

As a therapist, I encountered a new set of challenges, particularly the need to consistently

replicate key therapeutic elements that were inherently present in the outdoor setting. These elements embraced the continuous bilateral stimulation facilitated by movement, such as walking, alongside opportunities for clients to externalise their experiences through concrete, nonverbal creative expression—symbolically "constructing their struggle." This approach aimed to minimise reliance on verbal communication and promote gradual internal processing. The interaction between client, the setting and the horse/s, allowed for safe sharing, exploration and processing as horses provide non-judgemental and complete acceptance of the client. The effective integration of these components into each therapeutic session necessitated an intentional approach to ensure the intervention's efficacy within an indoor setting.

In equine-assisted therapeutic interventions, maintaining neutrality is relatively easy, as horses naturally respond to any external interference in the connection between themselves and the client. However, in a traditional therapy setting, the risk of personal biases or unconscious therapist intervention influencing the session is significantly higher, necessitating heightened self-awareness to mitigate such occurrences. Moreover, it was essential to recreate the sense of agency that clients experience in equine-assisted settings, where a growing awareness of self-worth fosters internal transformation. The goal was to translate the experiential and somatic benefits of working with horses into a creative and effective framework within the indoor therapy space, ensuring continuity in therapeutic impact while adapting to a different modality.

I had to replace the great big outdoor "sand tray with real horses", for an equivalent in the therapy room!

#### **The Role of Creativity in Trauma Processing**

As we know, creative modalities play a crucial role in trauma therapy by engaging the right

hemisphere of the brain, which is closely associated with processing an individual's internal state. For instance, Malchiodi (2020) discusses how expressive arts therapies can access sensory and emotional experiences stored in the right hemisphere, facilitating healing in trauma survivors, a point echoed by Schore (2022), who explains that right-brain emotional and relational processes operate beneath conscious awareness and are central to psychotherapy. Additionally, Schore (2009) emphasises the right hemisphere's dominance in processing emotional and bodily information, underscoring its significance in therapeutic settings that utilise nonverbal and creative approaches.

In their article *Right Brain to Right Brain Therapy: How Tactile, Expressive Arts Therapy Emulates Attachment*, Urquhart et al (2020) highlight the significance of the right hemisphere in trauma recovery. They explain that the right brain is dominant during infancy and is fundamentally involved in preverbal, emotional, tactile, and visual processing of lived experiences. As these experiences are often stored in the right hemisphere, this may inhibit or constrain verbal articulation of memories and/or experiences.

This hemisphere is also closely associated with imagery, metaphor, and emotional processing. Supporting this, Schmidt and Seger (2009) found that the right hemisphere plays a central role in metaphor comprehension, particularly for novel or less familiar metaphors, due to its capacity to integrate distant associations and manage figurative language. Researchers at the University of Rochester have explored how more than 50% of the brain's cortex is involved in processing visual information (Hagen, 2012). Similarly, data from the Perkins School for the Blind (n.d.) corroborate that over half of the brain's surface area is devoted to visual processing. This understanding supports the use of expressive arts therapy as a means to engage right-brain functions, facilitating healing in individuals who have experienced

early relational trauma.

Studies have demonstrated that the right hemisphere plays a critical role in emotional processing, attention, and arousal, and is instrumental in shaping and representing memories, emotions, and thoughts connected to past experiences. As Hartikainen (2021) explains, the right hemisphere is particularly engaged in integrating emotional and attentional processes, supporting its dominant role in detecting, prioritising, and responding to emotionally salient stimuli—especially those relevant to survival and personal significance. Additionally, research published by Gainotti (2019) suggests that the right hemisphere directly mediates the identification and comprehension and processing of emotions, particularly negative emotions and nonverbal emotional cues, while the left hemisphere contributes to higher-level processing of this information. These findings underscore the right hemisphere's significant involvement in processing and representing emotional experiences and memories.

Schore (2022) discusses how the right hemisphere is dominant for implicit, nonverbal, and intuitive processing of emotional information and social interactions, which are fundamental in psychotherapy. A study by Proverbio et al. (2009) examines the involvement of both hemispheres in language comprehension, highlighting the left hemisphere's dominance in processing literal language and the right hemisphere's contribution to understanding idiomatic expressions, which often rely on nonverbal cues. The right hemisphere processes nonverbal cues such as tone, facial expressions, gestures, and body posture, while the left hemisphere is responsible for logic, language, and verbal expression, contributing to meaning making.

These findings accentuate the specialised functions of each hemisphere in processing different types of information, with the right hemisphere attuned to nonverbal and emotional

cues and the left hemisphere focused on language and analytical tasks.

By working experientially and incorporating multiple sensory modalities in a safe therapeutic environment— such as sand exploration, expressive art journaling, and other creative approaches—clients are able to externalise and visualise their internal experiences. This process facilitates the expression of emotions and memories that may be difficult to articulate verbally or comprehend immediately.

The use of metaphors and projective techniques provides clients with a sense of control, allowing them to maintain psychological distance while ensuring safety. This approach enables them to gradually integrate fragmented experiences, ultimately converting implicit memories into explicit autobiographical narratives. In doing so, clients can begin to process and reorganise traumatic experiences in a more coherent manner.

This experiential approach aligns naturally with my practice, as it allows for the observation of both subtle and significant shifts within a single session or across multiple sessions. These shifts frequently lead to moments of insight, often described as "A-ha" moments— instances where a client experiences a profound realisation, such as recognising that the trauma they endured was not their fault.

However, trauma disrupts an individual's ability to regulate emotions and remain connected to their experiences. This dysregulation impairs self-regulation in the present moment, and discrepancies between verbal and nonverbal expressions can serve as indicators of underlying distress.

With the knowledge that trauma is stored in subcortical brain regions (amygdala, hippocampus, brainstem) that are not always accessible through verbal language, often

encoded as sensory fragments (images, body sensations, emotions) rather than logical narratives, the notion that talk therapy alone may not fully access deeply embedded trauma memories, is highlighted. The therapeutic goal is to modulate the amygdala's heightened stress responses, providing the hippocampus with the necessary conditions to facilitate cognitive processing. Techniques such as the sand therapy, various expressive exercises and creative journaling, exemplify how creative interventions facilitate and support this process.

When working with trauma, it is essential to assist the brain in transforming implicit, right-hemisphere-based memories into explicit, left-hemisphere-based content. By fostering understanding and meaning, this approach facilitates the discharge of the emotional intensity associated with traumatic memories, ultimately supporting the integration and resolution of past experiences.

#### **The indoor arena – snippets in the sand tray**

In the sand the sensory, emotional, and neural mechanisms activate to facilitate healing and integration, especially in areas related to implicit memory, arousal regulation, and sensory processing. The mind-body connection evolves and develops by engaging the sensory, emotional, and cognitive dimensions of trauma. By incorporating symbolism, relational healing, and nervous system regulation, it helps bridge past trauma with present feelings of safety. This allows individuals to process their experiences at their own pace while rebuilding self-awareness, emotional stability, and trust in relationships. And as in all trauma therapy, it is important to remember that the healing process is nonlinear. Clients may revisit past themes, experience setbacks, or oscillate between the different stages allowing this journey ultimately to move from dysregulation, fragmentation, and trauma re-enactment toward integration, empowerment, and resilience.

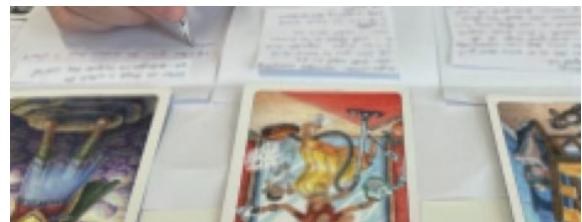
In this process of visually externalising trauma, the therapist plays a pivotal role in fostering a therapeutic environment that ensures the client feels safe and supported. By maintaining this contained and secure space, the therapist facilitates the emergence of traumatic memories, enabling the client to confront and process the deeply distressing aspects of their experiences as they surface while close clinical observations support the client to remain grounded in the present moment, thereby reducing the likelihood of dissociation.

At first glance the process of sand therapy, to which I will refer to going forward as Sand Explorations, the term I use in my practice, assumingly seems relatively simple. It is “just putting things in a sand tray”, as some clients would clarify, but once the tray unfolds the story, it quickly moves to the unconscious narrative wanting to be heard. As therapists we need to remain present and attuned to the process, providing a reflective and supportive presence, always remembering that we are on proverbial ‘holy ground’, and need to stay mindful to not hijack the process. It often is a slow process – the power of silence being very present and something we as therapists need to be comfortable with. This is where the therapist needs a thorough understanding and experience within the world of trauma therapy, to ensure its effective and ethically sound application.

Jasmine\* is in her early forties and has experienced significant childhood neglect and trauma, further exacerbated by multiple distressing events over the past decade. She exhibits dissociative tendencies, struggles with depression and anxiety, and engages in self-destructive behaviours as coping mechanisms. When triggered, she experiences significant difficulty in verbal communication. In many instances, interaction is facilitated through written exchanges during sessions. However, it is within the structured setting of the RS

Table—an adaptation of Fraser’s Dissociative Table Technique (Fraser, 1991)—and the use of various sized sand trays that she is most able to access and express, and perhaps process, some of her pain and fears.

Jasmine liked the idea of the RS-Table, so that is where we started our journey of getting to know her internal world and each of the dissociative states that came forward. Each internal state was assigned an identification card (in this case, the Inner Active Cards for Parts Work by Sharon Eckstein were used), and, once gathered around the table, each part introduced itself under the guidance of the adult self, Jasmine. They shared with each other when they came into existence, the role or the job they took on, and whether there is anything else they would like us to know. We sorted them onto different papers to help Jasmine explore the system.



***Jasmine’s account of the session (as typed by the client):***

*Didn’t take long for me to shut down and push her [me the therapist] away.*

*It was like I was both in the room and out of the room. One part of me was listening to her [me the therapist] saying re no blame, no shame, no guilt bla bla bla whilst the other part (the little hurting me) was totally out of the room and not interested in a word she was saying.*

*Was really interesting how she [me the therapist] dealt with it all.*

*Very factual which helped ground me a lot. First she asked me how many parts there were in the session - three - the 9yr old me, the 11 yr*

*old me and the now she gave me a big pack of cards with all different people. All sorts of people doing all sorts of interesting things I was to sift through them and assign one per part.*

*So, was interesting.*

*There was a cute little girl, out in the sun, hands out, enjoying life, that was me of 9. Little me saying look at me. I'm cute. I'm loveable. Please just love me for me.*

*Then there was a big fat panda bear. That was also me of 9, saying I'm fat, please don't tease me. There was one more that I chose for age 9. Little me standing on the table with family around me teasing me and I'm saying to please accept me and not tease me.*

*Next is age 11.*

*2 cards for this one.*

*1 is a tornado that's destroying everything, that's me sh and destroying myself.*

*The other is me being bullied by all those around me and it's me saying I've given up on life. Given up on myself. Given up on those around me.*

*Page 3 actually became the me of the future/present but good parts.*

*One was me sitting surrounded by my kids and full of love*

*Second was me walking the opposite way to hub.*

*Another was a small girl dancing in the sun and flowers and totally carefree and open to the environment and full of love.*

*Last was me multitasking and being supermum, superwoman, superwife.*

*Last page, page 4.*

*This page is full of distractors. I call them destructive distractors.*

*One was me all frazzled with tonz of lists flying around the place and trying to hold everything together but just sh to not feel anything. Second was a me that masks everything and shows the world that I'm amazing and coping*

*when really I'm falling apart inside 3rd one is me as a fat man with a huge storm over my head and sitting all gloomy. That's me dissociating and inside is tonz of anger and turmoil.*

*4th one is me frazzled, feet up, binge watching tonz of movies of bad memories with all the good ones locked up. That's me saying that I'm an attention seeker, I'm annoying, I make things up, I exaggerate.*

*So, this whole last page are parts of me that are important parts. Why? Coz they kept me safe from a very young age. They don't have healthy tools but they did do their best to keep me safe. They r there for a reason. To keep me safe. As soon as get near any pain then they rear their ugly heads. They roar and shut me straight back down. So now what? Now we need to befriend those parts. If we shout and push them away etc then they'll just dig their heels in and get worse/stronger. They need me to somehow befriend them and show them that I mean no harm and somehow move forward alongside them rather than fight them etc etc.*

*So, I've chosen to first befriend the big fat dissociating me. I've chosen to connect with him. Not sure how. I've chosen him coz he stops any sort of healing. He's the most present right now and he's really fat and is blocking a huge part of my recovery with his big fat lump.*

*Was so grounding when u [me the therapist] got on the floor in session. Actually, was more than that. I wasn't on the floor. U were. I felt a bit like I was in control. I was choosing the cards. I was expressing them etc. It felt good to be in control in a totally uncontrollable situation. Thank you.*

Jasmine chose to continue with the RS Table during this particular session. Once all checked in, Part 6 (one of the young states) mentioned that she feels too vulnerable to participate.

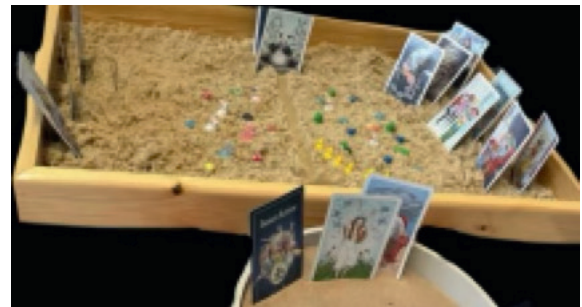
As the therapist, I gently invited Jasmine to propose an alternative, more creative mode of communication to Part 6—such as writing—so that verbal expression would not be necessary if it felt too difficult. Part 6 agreed and chose the sand tray (a medium Jasmine has worked in before). Part 6 chose the Leader (Adult Jasmine), and Parts Tornado and Dissociation to go with her. A small tray was offered to the system. Jasmine started constructing the tray – a barrier with wooden buttons, adding a gold crystal and Part 6. In the middle she created a circle of various colours of crystals (representing all the other parts) and a wooden



flower in the middle, adding the Leader. The other two parts were placed outside the circle. She wrote her explanation (Jasmine struggles to talk when Dissociation is present) that the other parts were all talking to each other, and they left a space for Part 6 to join – but she can't. Encouraging discussion between Part 6 and the Leader, Part 6 was invited to join her. For the remainder of the session, the Leader spent re-assuring Part 6, sitting with her, spending time with her, till she felt calm enough that she could breathe again.

During a further session, Jasmine invited her Parts to the table as the youngest part (Part 1) requested permission from the system to have the part Anger speak. Part 1 expressed that for her to heal, Anger needs to be allowed to speak – which, up till now, he has been denied by the system. The sand

tray replaced the RS-table today, and all parts gathered. It was interesting that they seemed polarized today – those 7 supporting Part 1 fully, and those not sure it is the right thing to do. During the initial dialogue between part 1 and Anger, the latter of the parts became



unsettled, and Part 1 was requested to stop the discussion. A suggestion was offered to move the discussion to another, smaller tray (physically removing them from the big tray, but allowing the system to witness and hear their interchange). The system and Part 1 agreed, as did Anger.

Moving out of the main tray, Part 1 requested her protector (Dissociation) and the Leader (the adult Self) to join in the tray. We asked permission from Dissociation to observe today, and not to step in unless there is really a need for his protection. He agreed, and during the session, we made a conscious effort to regularly check-in with the system and Dissociation regarding their feelings and needs. The system stayed settled for the remainder of the session while powerful dialogue followed.

Gail\* is in her early thirties. She experienced childhood emotional neglect and abuse resulting in some wounded young dissociative states. They have not been allowed a voice till now, and since starting therapy, Gail and her system responded very positively to some creative techniques. The younger states showed up in images and shapes, and shared some of their needs, allowing us to start to get to know the system. The option of working in the sand tray

was introduced and it was interesting to notice the system's initial extreme aversive response to this. The sand tray was then introduced with care. Externalising the dissociative states – the protectors in relation to the wounded young parts – helped Gail to deepen the relationship with some of her states in the process of getting to know their pain, fears and struggles, clearly portrayed in her comment:

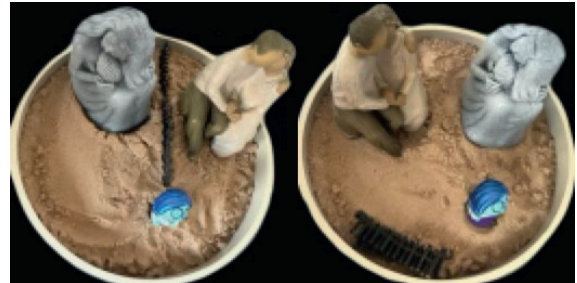
*... think I've gained some clarity over the last couple of days re the horrible discomfort I've had coming up. It's what we built up in the sand which I understood intellectually but was struggling to connect to my reality. Now I feel like I've put it all in place.*

Jess\* is in her mid-thirties and coming from a home where she experienced severe childhood sexual abuse. Her sand tray shared



the story of her dissociative state that is too ashamed to face those close to her due to this. How this state of her is avoiding, looking away, struggling to make contact. The states putting up the “fences” and preventing her from moving closer was present, amidst “lower” than when she started therapy years ago. Jess slowly processed her tray, with her states realising that she needs to request those that are holding the “fences” in place, to change, to let up, and to help her gain the confidence to assist Shame to move forward – even if just baby steps. The fences were removed – and the Shame state courageously turned to face those close to her and to help her gain the confidence to assist Shame to move forward – even if just baby steps.

In some sessions, clients' nervous systems



may be too overwhelmed to engage with the sand tray. On certain days, they may experience fatigue or need to direct their attention toward other pressing realities. However, when the therapeutic process requires engagement with distressing emotions, the sand tray is reintroduced as a tool to facilitate externalisation of internal experiences. This method, despite its seemingly simple nature, provides a contained means for clients to progress on their healing journey.

The process of shaping sand, selecting miniature objects and figurines, and constructing a visual representation in the sand tray can be influenced by both conscious and non-conscious cognitive mechanisms. For trauma survivors, in particular, the creative process may emerge directly from implicit, sensory-based memory, resulting in spontaneous expressions that the client may not be able to fully articulate.

The sand tray also demonstrates its value in the initial stages of therapy. The rapidity with which different aspects of the self-reveal who is present and who requires a voice remains remarkable.

Round about her fourth session, Penny\* was invited to create a sand tray representation: “who is Penny.” As a new client, early in her therapeutic journey and highly motivated to work on her healing journey, she was reminded to allow the symbols to choose her as she began exploring the shelves, taking her time in selecting items for her tray.

She constructed her tray with some hesitation and, upon invitation, shared its significance in

relation to her identity. Her initial explanation was highly cognitive, consisting of known facts about herself. The arrangement of her tray formed a triangular composition, with a symbol representing herself (an 'ugly, weird looking'), the bottom point of the triangle, and at the other two ends featuring the "the Devil"—which symbolised her feelings of sadness, loneliness, and disorientation—and "Hope"—representing happiness, positivity, and optimism. When asked whether this placement was intentional, Penny paused in thought and became visibly emotional.

She reflected, "When I feel like this" (gesturing towards the Devil), "I am unaware that that" (pointing to Hope) "even exists. It is always one or the other—as if they do not know about each other."

This simple request—gently shifting the metaphorical curtain—offered valuable insight



into Penny's internal system and personal world.

### Conclusion

I have shared a few examples to demonstrate the effectiveness of sand exploration in working with adult clients experiencing dissociation or dissociative symptoms—whether they are aware of it or not, and regardless of a "diagnosis". This approach is something I am deeply passionate about, almost as much as about equine-facilitated interventions.

As Boik and Goodwin (2000, p. 3) describe, it is "... a practical, experiential tool that can create a bridge from the unconscious to the conscious, from the mental and spiritual to the physical, and from the nonverbal to the verbal."

As a therapist, it enables me to witness and facilitate the client in both restoring and re-storying their life narrative.

Would you like to build your world for me? 🌍

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An illustration of a young child with brown hair, looking down with a sad expression. The child is holding a yellow sign that says "YOU ARE KIND". In the background, there are two more signs: a yellow one on the left that says "YOU ARE KIND" and a green one on the right that says "YOU ARE LOVED". The child is sitting on the floor, and the background is a warm, textured brown color.

YOU  
ARE  
KIND

YOU  
ARE  
LOVED

# COGNITIVE CONSTRUCT OF THE SELF – DEVELOPING A BASIS FOR A FUNCTIONAL SELF IN CHILDREN WHO SUFFERED SEVERE EARLY COMPLEX TRAUMA AND DISSOCIATION

By: Renée Potgieter Marks

The Structural Dissociation theory (Van der Hart, Nijenhuis & Steele, 2006) remains one of my favourite theories to explain dissociation in children and adolescents, specifically for two opposing parties in a meeting where professionals are totally unfamiliar with the complexity of dissociation and the multiple representations of the self. These are the moments where the introduction

to the Structural Dissociation, specifically the Apparently Normal Part of the personality (ANP) (Van der Hart et al, 2006) and the Emotional Part of the personality, (EP's) (Van der Hart et al, 2006) create insight and understanding enabling professionals to work together in the best interest of the child or adolescent. It is the functional ANP which can be very confusing for people when they are suddenly also confronted with the multiple EP's whose activity often causes major concerns about 'behaviour'.

Over my 18 years in practice working with 10 – 12 other therapists, all specialising in complex trauma and dissociation, I found that there is a large group of children who never display an ANP or even any functional behaviours. I questioned this and I wondered why these children did not display any functional behaviours at all? Where was the ANP? Did they even manage to develop an ANP? Over time, reading hundreds of assessment reports and years of clinical supervision of therapists working with me, I noted the therapists all highlighted complex trauma and dissociation in most of the children. I also realised that the group of children who did not display any ANP behaviours were all traumatised very early in their lives, usually in the first year of life and often also during the prenatal phase. I realised that if the infant lives in a totally chaotic home, where different types of abuse and neglect is happening as part of the 'daily routine', there is no space for the self to develop in the way that it should. The sense of self that the infant and toddler develops depends on the interpersonal relationships, the external environment, somatic experience and whether these experiences are mainly pleasurable or painful and elicit fight, flight and freeze responses. Outside of a relationship, where the infant is emotionally contained, comforted, loved and adored, there is a much more distorted view of the self which develops. A rejectable self which deserves to be consistently or intermittently ignored or hurt.

We, as a group of therapists, have always been very aware that the children we see have a capacity to move towards full integration, which over the long term provided evidence of very well-functioning adults, without any signs of complex trauma and dissociation. Silberg, (2022) also states that the children are in a process of developing dissociative disorders. The fact that the symptoms of dissociation in children can be treated effectively, was a motivating factor to make more sense of the absence of an ANP in many children.

Integration is defined as the action or process of combining two things in an effective way (Cambridge dictionary). How do we 'integrate' dissociative states if there is no visible or experienced sense of a functional self in the child?

Looking at the information from Stern (2006), who wrote about the self-development of the infant, it is a prerequisite that the infant functions in relationship with the adult, where attachment, care, play and love are part of the 'daily routine'. Within this relationship where there is constant positive feedback to the infant, the self can develop like a little seed, which landed in fertile soil, has sufficient nutrients, water and sunlight. In the absence of this, the infant's brain develops totally different responses. Adults become dangerous, threatening, confusing, and hurtful. The natural response of the brainstem in the presence of adults elicits freeze, flight or fight responses. The goal of daily life becomes solely a struggle to survive, suppressing the pain and internalising the anger, depression, anxiety, or violent and neglectful adults. Sleep becomes dangerous, food becomes a weapon, the body becomes the object of another's anger, frustration and distortions. There is no time, no space, to develop a self, let alone a functional self. But what happens to the self that does not develop? Does it develop, but only in a negative way? Does it get stunted, frozen by the trauma, which happens again, again and again, never-ending?

My experience with four-year old Jamie started to help me understand some of the answers. His background and first 18 months were extremely difficult and complex. Extreme neglect, physical, sexual and emotional abuse became his 'daily routine'. But he survived. He was adopted by a very loving couple, who adored this little boy and loved him.

During the second therapy session, Jamie went

to the dustbin. I watched him carefully. He knelt and put his whole head and upper body in the dustbin, and there he was half in the dustbin and half out of the dustbin. I had to suppress my instinct to 'save' him out of this unhealthy environment, and asked, 'Jamie, what is happening?' A somewhat muffled answer arrived immediately. 'I am rubbish'. I had to repeat my question, just to convince myself that I heard correctly. The muffled answer remained the same. 'I am rubbish, in the bin'. I immediately reached for the book, 'Ruby and the Rubbish Bin' (Sunderland, 2003) and invited Jamie to come and listen to a story. He sat down, while his mother read the book to him. He very quickly became animated and pointed his finger to Ruby who was sitting in a rubbish bin, excitedly shouting 'That is like me!'. Without a moment of hesitation Jamie identified himself as rubbish, just like the character in the book. Over the next couple of months, I started to see how Jamie was painfully playing out the horrendous abuse he suffered, while living with the birth family. No complement, no praise was ever accepted by Jamie – he always disputed any good thing which was said to him. Of course, he was rubbish and rubbish is not good, it is bad, it needs to be thrown away!. How could the adults around him not understand this? It was the only message he received during the first 18 months of his life.

Jamie made me think even more about the developing self of the infants with complex trauma. There is no space for developing the self. What I saw reflected a distorted belief system, which became the mirror of all his accumulated abuse and neglect over an extended period.

I wondered whether there was a way to change this distorted belief system. At the end I started to develop a therapeutic technique, namely the Cognitive Construct of the Self which my colleagues and I have now used for many years successfully.

When Jamie arrived for the next therapy session,

I asked Jamie to lie down on a big piece of paper. He complied. I asked the mother to draw around Jamie so that we could have an outline of his body on the paper. Jamie's mother explained what she was going to do and that it would not hurt him. He looked suspicious but stiffly remained on the paper while the mother slowly drew all around his body while providing running commentary about his head, body limbs and how it all connected to make her beautiful boy.

When the mother finished, Jamie jumped up. The mother wrote his name and his age at the top of the paper, and we stuck the paper to the wall. Jamie looked at the outline of his body. 'I am big!' he shouted, as if he could not believe his eyes that he was the size he saw in front of him. We agreed and measured him against the outline – he was really this big! Jamie smiled and moved to the tractor he adored and started to play.

I provided the mother with a pack of yellow Sticky Notes and I took the green ones. I asked the mother to write one positive trait, quality or ability on each note, that she knows that Jamie is or can do. She started immediately. I started to write similar information on mine. After some time, we finished, just in time for Jamie to lose interest in the tractor.

I called Jamie closer. He could sit on the little chair with a lolly he could suck, while listening to what 'Mummy' and the therapist wanted to let him know. I started and stuck the first Sticky Note inside the outline of his hands, on the paper, which was still on the wall, representing 4 year old Jamie. It said, 'Jamie you can help very well'. Jamie did not give any clues as to what he might be thinking, just stared with his big brown eyes. I continued 'Can you remember when you came in today, I accidentally knocked the pens off the table?' He nodded. 'And who helped me pick them up?' 'Me' Jamie shouted. 'Yes, that was even before I could start to pick up anything, you were right in there and 1,2, 3 picked up all the pens!' Jamie laughed – he got it! He was

helpful. I felt relieved that Jamie was able to remember and accept this fact about himself. This moment was certainly different from all the other attempts to try and enable Jamie to realise his abilities and his worth.

The mother placed the next message on Jamie's foot. 'Jamie can kick a ball very well!' While Mother continued to explain how well Jamie could kick, he jumped up, grabbed the ball and illustrated his kicking skills. Jamie was starting to enjoy this. This was not praise, this was not a compliment. This was an actual reality, which Jamie knew that he could do – he just never had any space or time to start internalising that he can also do good and positive things – he was not only rubbish after all!

Over the next weeks and months, the outline of '4-year old Jamie' was on the wall during every therapy session. Each therapy session started with celebrating something we had evidence of which Jamie could do. After the second week, Jamie refused to accept the fact that he could ride his bicycle. The next week the mother produced photos as evidence which instigated a more elaborate discussion on how 'clever' Jamies' arms, hands, legs, or feet were. Jamie enjoyed the photos or videos which 'proved' to him that he could indeed do good things.

Although Jamie tried two more times during therapy to place himself in the rubbish bin, it appeared half-hearted and he quickly moved out, as if he was not certain whether he belonged there any longer. Over time, Jamie started to thrive, not only during the attachment therapy, but also in terms of his physical and cognitive abilities which started to radically improve. The weekly celebrations continued until his therapy was finally completed. Jamie was able to integrate his multiple dissociative states (all starting to 'help' the 4-year old Jamie) and he started to change, not only in terms of what he believed about himself but also in terms of who he was as a person.

The Cognitive Construct of the Self (CCS) also provided insight in some of the other children. 12-year old Paul, immediately fell off his chair when the first message appeared on the outline of his body. He moaned and groaned and became very distressed. This provided the ideal opportunity for the parent to join Paul on the floor and cuddle him; while lovingly expressing an understanding that 'little Paul' did not feel it was right for him to even look at anything good about himself. Little Paul really struggled when he was little, as he only ever heard bad things about himself and started to believe that he is all bad. Paul slowly calmed down, while sucking a bottle of water, sitting with mother. In the case of Paul, using the CCS was a much slower and measured process. It was still used regularly, but all abilities or achievements were illustrated in the therapy room with photos, videos and real-life evidence, and only 1 message was produced per therapy session. Until one day, Paul asked for the Sticky Notes. He took a pen and wrote 'I can sing'. Finally, Paul started to develop some understanding that he had some abilities which provided him with worth. After this action of Paul, the CCS could be used more regularly.

During therapy 9-year old Stacey, explained that the baby was 'frozen'. It was evident that this baby was critically important to work with, but as it was 'frozen' we could not access it. After literally freezing a little baby doll and Stacey helping the therapist to defrost the "baby," slowly a very excited Stacey was able to start to access the very young baby state and started to appreciate the information on the CCS. The CCS was initially sent home with the parents to use with Stacey during the week. Then it vanished. The mother found it torn in the bin. Somebody totally rejected the information on the CCS. We started to use it again in the therapy room and have since decided that it might be better used as a therapeutic tool in the therapy room, as some dissociative states might destroy it at home.

Adolescents were too big to fit on the paper and would never accept the closeness of another person to draw the outline of their body. I usually ask the parent to measure the height of the adolescent, after which the adolescent could draw the outline of their own body, often with some help from the parents. The adolescents were also then more eager to write their age and name at the top of the paper.

The CCS did not bring radical changes in children and adolescents, but it was a slow process of learning about and highlighting their internal world (often an internal jail) where chaos, distorted thinking, voices, noise, internal shouting, anxiety, depression and self-deprecation reigned. The process also raised awareness of the external world in which others were noticing real positive abilities, traits, characteristics and actions, which were appreciated, adored and enjoyed. The child held within the internal jail was slowly vindicated and released by the gradual acceptance that others (often different people seeing similar traits, abilities and actions) could not all be wrong in their experience of the child, and it might all really be part of a 'me' who exists.

After each birthday, a new version of the outline of the child is often drawn. This provides a new opportunity to relook at the self where the therapist and parent will refrain from writing, and the child will write down everything they have started to believe about themselves. It has been interesting to see that the child and adolescent does not necessarily incorporate all the information previously offered by the people who know them. Instead, they mostly add other qualities which they themselves have become aware of. Over time the child uses this cognitive construct to develop a more functional self, which becomes increasingly functional after the integration of each dissociative state.

## Conclusion

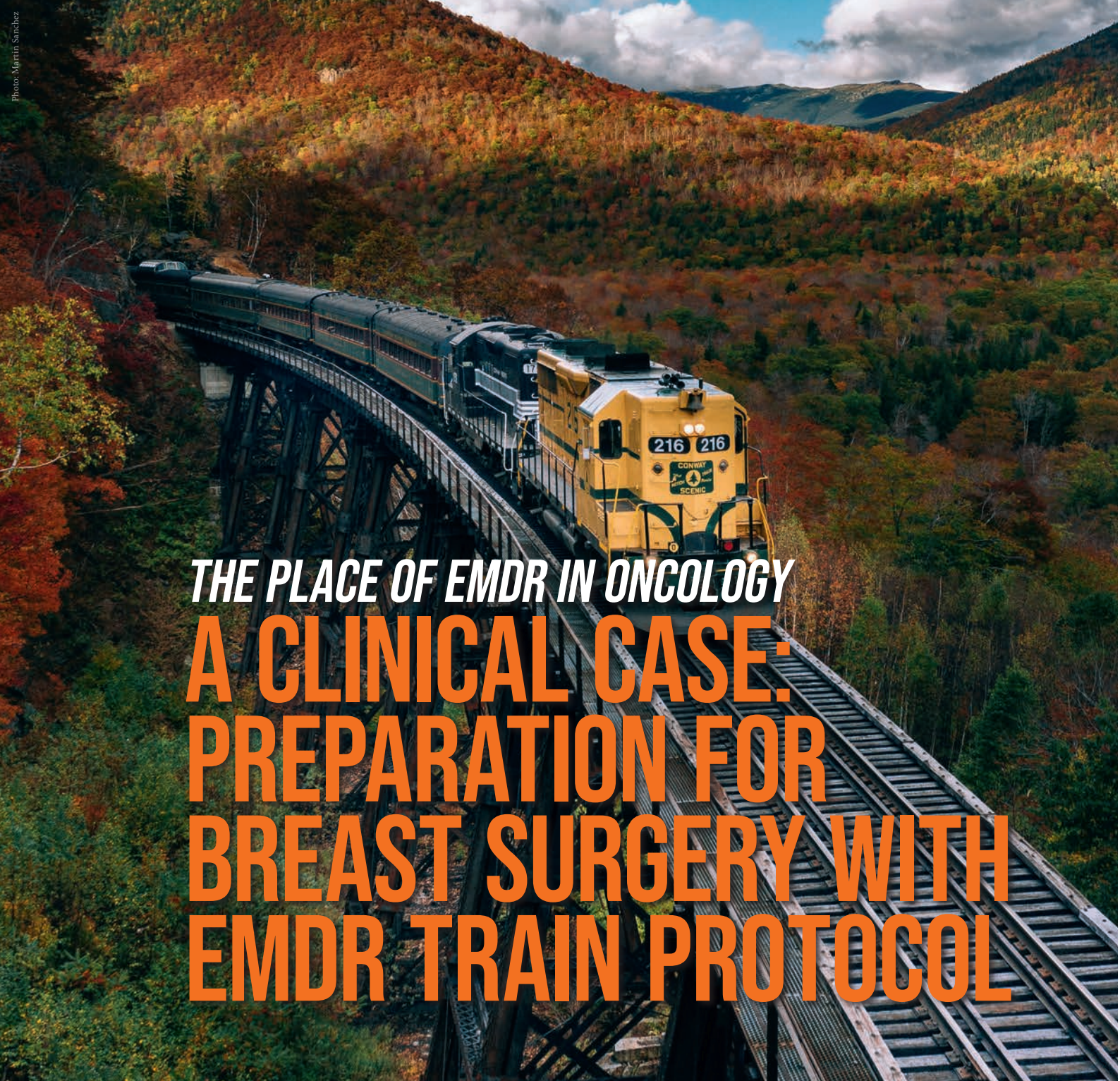
The Cognitive Construct of the Self is a therapeutic tool, specifically for children and adolescents who suffered significant early trauma in their lives and

who have dissociative symptoms. It provides for the self a 'get out of jail' card, hope, new horizons and intense joy over time. Most of all, it makes integration of dissociative states much easier and is part of a process of assisting the child to move from a bundle of pain, experiencing themselves as 'rubbish' to a more functional self.

The ultimate sense of self never contains the full cognitive construct but always contains strong elements of it with a whole new list of experiences of an internal self that can develop as the trauma is processed and finally subsides to make space for the original self. Some adolescents announced that for the first time in their life they felt 'strong' or that they 'finally feel human', 'can think' and that they now know they 'have worth!'

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# *THE PLACE OF EMDR IN ONCOLOGY* **A CLINICAL CASE: PREPARATION FOR BREAST SURGERY WITH EMDR TRAIN PROTOCOL**

By: Vanessa Grandjean

## **Introduction**

The list of serious illnesses, including cancer, continues to evolve every year. Thanks to improved treatments, some of them can be managed effectively.

Others are becoming chronic and, unfortunately, some have no treatment at all. The diagnosis and medical course associated with the disease are often accompanied by a series of traumatic experiences and stress, with major consequences for patients' quality of life

(D'Andre et al., 2024). Psychological support is essential to accompany patients and their families (Archuletta and Grandjean, 2023). Using different therapeutic approaches, psycho-oncology supports patients in their medical process and aims to improve their quality of life throughout the course of medical treatment (Razavi, 2019).

Alongside other therapies, in particular cognitive-behavioural therapy (CBT), a new therapy

emerged in the 1980s in the United States and is one of the new innovative psycho-oncological interventions. EMDR therapy (Eye Movement Desensitization and Reprocessing) (Dolbeault et al., 2022) is based on an information processing model accompanied by a standard protocol for the treatment of psychological trauma (Shapiro, 2017).

What role can EMDR therapy play in the psychotherapeutic support of oncology patients? What adaptations are necessary depending on the patient's physical state and medical situation?

Our clinical practice has led us to adapt the standard EMDR protocol by incorporating the patient's medical follow-up. To do this, we used the metaphor of the train, which represents the patient's journey through the illness. This drawn metaphor will serve as the basis for adapting the standard EMDR protocol for oncology therapists. We have called it the EMDR TrainProtocol.

In this article, we look at the use of EMDR with the Train Protocol in the context of support for a patient undergoing a mastectomy.<sup>1</sup>

### **The place of EMDR in oncology**

There is still some debate as to whether life-threatening illnesses can cause traumatic states as defined in the DSM V. There are no guidelines on this subject (Tarquinio, 2022). The prevalence of post-traumatic stress symptoms in oncology fluctuates according to research (Fortin et al., 2021). **1 This operation consists of removing the breast in the case of cancerous tumours.**

Some researchers have pointed out that the brain regions involved in PTSD symptoms in cancer patients appear to be the same as in those suffering from PTSD related to other psychological traumas (Acevedo-Ibarra et al., 2022; Carletto & Pagani, 2016, 2018; Unseld et

al., 2019). Indeed, patients followed in oncology present the same symptoms as patients who have experienced trauma.

In the field of psycho-oncology, it was Capezzani et al (2013) who conducted the first study looking at the treatment of oncology patients with EMDR. This study demonstrated the major efficacy of EMDR compared with CBT in the treatment of post-traumatic stress disorder (PTSD) in oncology patients during the follow-up phase. This concerns a reduction in PTSD symptoms and the impact of life events.

Several adaptations of the standard protocol exist, including one for cancer patients developed in 2016 (Faretta & Borsato, 2016). The latter highlighted that the level of emotional distress associated with each phase of the illness requires specific reprocessing work to promote the patient's coping strategies.

EMDR therapy is used in oncology to help patients cope with the emotional and psychological difficulties associated with their cancer diagnosis and treatment on an individual and group basis (Jarero et al., 2016, 2017, 2018). The studies highlight a significant difference in pain management (Brennstuhl et al., 2017), emotional management (Pomeri et al., 2021), an improvement in anxiety and depression symptoms (Capezzani et al, 2013; Faretta & Borsato, 2016; Haerizadeh et al., 2020), boosting self-esteem and body image (Bruin et al., 2023), helping to deal with the fear of recurrence (Bruin et al., 2023) and also in palliative care (Mélin, 2018 ; Martin et al., 2023).

By training in Ericksonian hypnosis and EMDR, we wanted to adapt our knowledge to the needs of oncology patients. Indeed, as explained above, throughout the course of a patient's medical treatment, they go through difficult times, which can be a source of trauma. So, we have conceptualised this journey in the form of a metaphor. We called it the Train Metaphor. This

metaphor became a drawing, and this drawing became a working protocol for the EMDR therapist in oncology.

This train protocol (Grandjean, 2023) makes it possible to adapt from session to session to the patient's level of distress and/or need. It is particularly relevant because it makes it possible to adjust the intensity of the intervention (e.g. adapting the duration of sessions) according to the patient's conditions (e.g. during chemotherapy treatment).

#### **Preparing for a mastectomy with EMDR**

We assumed that preparing for surgery with EMDR could enable the patient to improve her perception of her body, her self-image and her quality of life in the postoperative period, and prevent the onset of post-traumatic stress symptoms.

Some patients report difficulty looking at themselves in the mirror and touching the part of their body that has been operated on. This long-term avoidance leads to psychological after effects that affect patients' quality of life, their relationship with their body and their sexuality.

As Dolbeault et al (2022) point out, the ordeal

of cancer requires patients to make repeated psychological adjustments in response to the various trials and events that such an illness confronts them with. Many situations experienced intensely during the course of treatment are likely to generate traumatic disorders, including announcements, examinations, surgical procedures, etc.

#### **From the train metaphor to the EMDR train protocol**

##### **The train metaphor**

When a patient is diagnosed with a serious illness, the continuum of their life is turned upside down. They are propelled into a new world, often unknown and frightening, with a loss of control, a destabilisation of beliefs and a fear of death.

We propose to represent this change of state by the passage in a train, whose various carriages represent the patient's medical journey. This is what we call the train metaphor, and it is drawn with the patient during the consultation. They will be able to refer to it at any time for themselves, their family and their work with the therapist.

Figure1 : the figure of a train: entry, set-up,



## ENTRANCE



## EXIT



chemotherapy, radiotherapy, operation and exit

### The train entrance

Entering the cancer train means discovering the disease. This is one of the most difficult moments in a patient's journey and corresponds to the emotional shock of the diagnosis. At the time of admission, the patient does not yet know what to expect, either in terms of the severity of the disease or the treatment. The time it takes for the train to build, i.e. how many "treatment" carriages, is a pivotal period, a source of anxiety and questioning for both the patient and their family. There is an internal reshuffling towards the unknown: new people, a new vocabulary. The patient is alone on the train.

### Setting up the wagons

Once the results of the various medical examinations are known, the oncologist can begin to plan the medical course. This is when the rest of the train takes shape. Different carriages will represent the patient's medical steps: chemotherapy, operation, radiotherapy, immunotherapy, hormone therapy, etc.

From a clinical point of view, we also note that emotional distress diminishes: the effects of the state of shock fade. The patient recovers some of his cognitive functions and regains some control over his life. In fact, an action plan and a program have been drawn up to combat the disease.

When patients begin their treatment, they learn about each carriage (the care staff, the impact of the treatment on the body, the side effects, etc.). For some people, the change of treatment (wagon) can lead to a further increase in emotional distress. This is a new step.

There are two possible scenarios when designing the carriages with the patient. When the wagons are stuck together, the patient moves from one treatment to the other naturally. However, between certain carriages, there is a gap. This can become a source of stress and uncertainty for the future, with the presence of anticipatory fears. There is a new treatment, a change of team, a change of location. The patient may need to be prepared for this change of carriage.

Depending on the situations experienced in the carriages, the brain does not always have time to recover from the stresses experienced. These stresses accumulate more and more, leading to major disruption. This new destabilization impacts on the patient's quality of life and can lead to the emergence of post-traumatic stress symptoms. It is therefore important to help the patient to be vigilant and attentive to these different stresses.

### Getting off the train

When the treatments are over and the person can finally get off the train, other psychological symptoms appear. Paradoxically, the patient's 1st thought when they get on the train is to get off and get their old life back. Once they have got off, patients want to stay on. They feel medically safe there. It's a feeling of withdrawal. They feel supported, supervised and helped throughout the process. They must learn to resume their life as before, considering the physical and psychological upheavals caused by passage on the train. This is far from easy, as the slightest sensation in their body makes them think of illness or a recurrence.

### And when you can't get off the train - chronicity of the train

Unfortunately, treatments are not always effective. Some illnesses become chronic and can get worse. As time goes by, new carriages are added. The patient can no longer envisage getting off the train. This notion of chronicity imposes a major psychological adjustment on both the patient and those around him. It means learning to live with cancer.

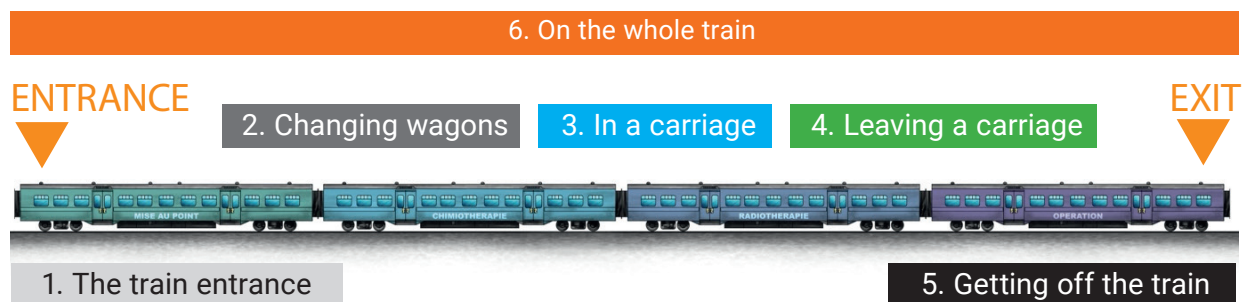


Figure 2 : 6 of 8 ways of working with the train in EMDR

#### The EMDR train protocol

To provide patients with the best possible support during their treatment, we have developed an adjusted EMDR protocol. We call it the "train protocol". It allows the therapist to adapt from session to session to the patient's level of distress and/or need. This new protocol is particularly relevant because, as we have already pointed out, it allows us to adjust the intensity of the intervention to the patient's condition.

The train protocol involves identifying the most difficult moments that will become targets for EMDR therapy.

We also emphasize the importance of developing the patient's resources, and closing each session with a stabilization exercise based on the patient's

neutral or positive feelings. We currently identify eight different ways of working with this protocol:

1. The train entrance
2. Changing carriages
3. In a carriage
4. Leaving a carriage
5. Getting off the train
6. On the whole train
7. Chronicity of the train

In this article, we'll take a closer look at changing carriages, using Rebecca's clinical case to prepare for her operation.

#### Changing carriages

Before setting off on a new journey, the patient may have fears about what is to come, a fear of the future.

Preparing for the wagon change can be done in two steps:

1. Work on the fear of the next train carriage by bringing out the fear of the future.

2. Use the resources you have learnt since you got on the train or in the previous carriage, dealing with targets from the past.

In fact, it enables patients to develop new resources and capabilities for the rest of their lives. It's a continuous learning process. Moving from one car to the next helps the patient to develop positive cognition, such as "I'm strong for having been through this car".

In the EMDR "wagon change" protocol, we will therefore assess the disturbance felt at two points with the patient:

- Before entering the next carriage
- Since entering the train

Depending on the number of carriages already crossed, there may be several moments. Based on the principle of the R-TEP protocol (E. Shapiro & Laub, 2008) we'll start working on the moment with the highest disturbance (past, present or future).

**Rebecca's wagon change: preparing for mastectomy**

Rebecca is a 38-year-old single patient. She is being treated for left breast neoplasia. We met at her request to prepare for her operation, a mastectomy. The patient is talking about her stress in the run-up to the operation, which is due to take place in a few weeks' time. She wonders what impact the surgery will have on her body and her self image.

We assess the possible antecedents and propose the container exercise<sup>2</sup> to enable work on the present.

**The feeling of confidence**

Before working on the problem situations again, we assess how confident the patient feels about starting work on the EMDR train.

In fact, verbalising the difficult moments and detailing them can bring out emotional distress. Bear in mind that, with cancer, a person can be physically unstable.

The assessment is based on a scale of 0 to 10. "0" represents no confidence and "10" one maximum confidence. In this case, the patient feels 9/10.

We explain the stop signal<sup>3</sup> and take the time at different points in the re-treatment to assess how the patient is feeling (importance of rhythm according to physical state). During the treatment, some patients may experience incapacitating side-effects that can be disruptive (e.g. nausea). Depending on the condition, sessions last between 20 and 40 minutes.

**Session 1: Drawing the train**

We draw the treatment train with Rebecca. There are 3 carriages: diagnosis, surgery and an empty carriage (Rebecca doesn't yet know whether she will have further treatments). We symbolise three arrows: the entrance, the exit and the moment of diagnosis and surgery. The train's protocol includes identifying the most difficult moments, which will become targets.

The patient's request concerns preparation for the next carriage, which is surgery. To do this, we are going to assess the disruption felt at various points in the train before the surgery and since entering

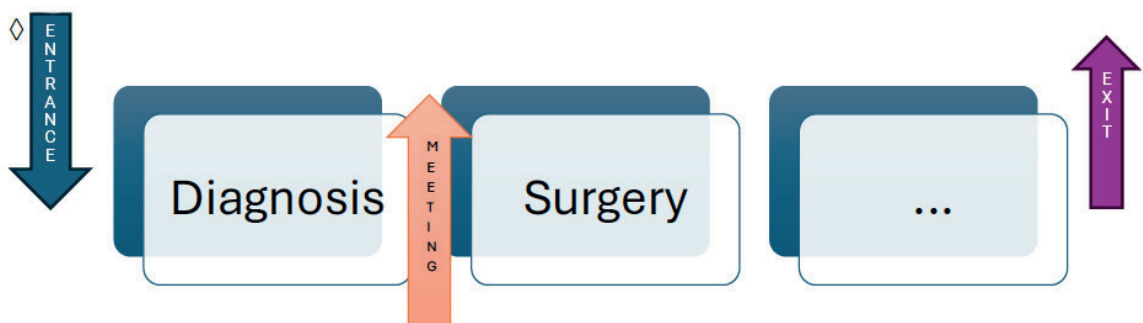


Figure3 : Rebecca's train: entrance, diagnosis, encounter, surgery, unknown carriage and exit

the train.

**- A: before entering the surgery carriage**

2 This is a visualisation exercise, in which the person imagines that the disturbances that are not being worked on will be deposited in a container (box, chest) that can be closed and put away.

3 It allows the patient to inform the therapist of a difficulty and to interrupt treatment if the process becomes too difficult.

"Today, in this session, when you think about your next surgery, how would you rate your level of psychological disturbance from 0 to 10? 0 means no disturbance and 10 means maximum disturbance"<sup>4</sup>

For the patient, the level is 7/10. This is when she imagines waking up.

- B: since boarding the train

"Today, in this session, when you think about getting on the train, how would you rate your level of psychological disturbance, from 0 to 10? Knowing that 0 means no disturbance and 10 means maximum disturbance".

For the patient, the level is 8/10. That's when she was diagnosed.

Based on the principle of the R-TEP protocol, we will start work now of greatest disturbance. Before that, we focus on the feeling of trust.

**Setting the target based on the moment of greatest disturbance.**

For our patient, this concerns the moment since entering the train, with a disturbance of 8/10. We begin phase 3 of the standard EMDR protocol. Rebecca verbalizes the most disturbing situation that represents this moment: "It's when I'm in the oncologist's office and he tells me I have cancer".

We begin phase 4 of the standard EMDR protocol by reprocessing the target with alternating bilateral stimulation (SBA). The patient prefers tapping on her knees to eye

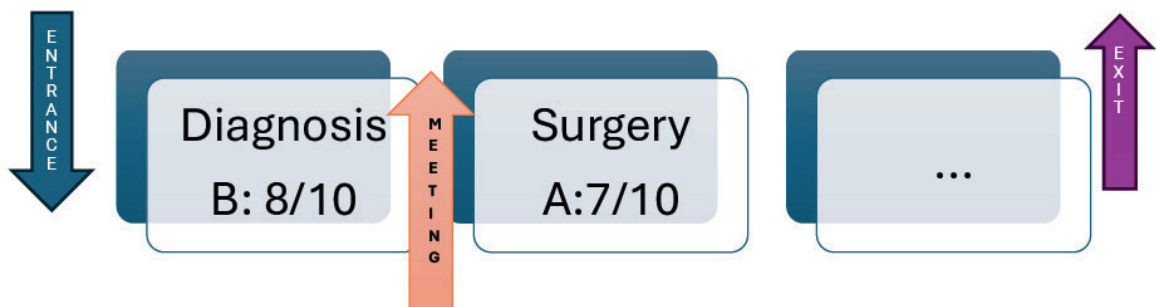


Figure 3 : Rebecca's train: entrance, diagnosis, encounter, surgery, unknown carriage and exit

Situation	I'm at the oncologist's
Image	The doctor's hands
NC	I'm lost
PC	I am able to
VOC	2/7
Emotion	Fear
SUDs	8/10
Body	Knotted throat

movement stimulation. The patient verbalizes her experience of this situation. We stop several times to assess how she feels. Stopping is a deviation from the standard protocol. We suggest it to respect the patient's rhythm, especially when she is also undergoing medical treatment. She authorizes us to continue. The patient verbalizes feeling calm and soothed. When we ask her to think back, she says she

<sup>4</sup> We call it SUD: Subjective disturbance units

feels her body relaxed. She wants to stop. We assess her SUD, which is 3/10.

We end the session with a relaxation exercise based on the feeling of her "relaxed" body.

**Session 2: target replay "from the moment you got on the train".**

Rebecca describes her experiences since the first session one week ago. She felt very tired just after the session and then continued to enjoy the calming sensation. She verbalizes her experience since the 1st session 1 week ago. She felt very tired just after the session and then continued to enjoy the calming sensation.

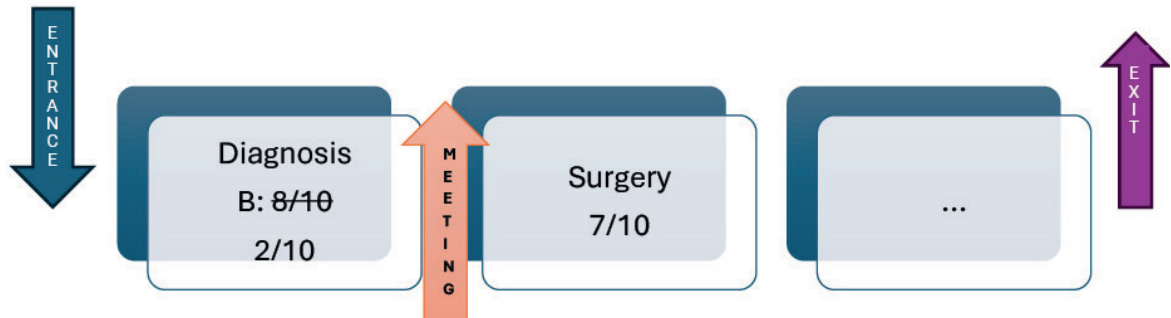
We return to the target worked on during the first session. We resume a mini-phase 3. She explains that she can see the oncologist's face, her SUD is 4/10 and her throat is tightening, but less than before. We resume the SBA. She soon

verbalizes that she feels her throat loosening.

The SUD is down to 2/10. We discuss what this 2/10 means. The patient expresses that it represents what she still must go through, the next carriages on her train. We check whether this value is right for her. It is 5.

We enter phase 5 of the standard protocol with a discussion of the basic positive cognition "I'm capable", which has become "I'm strong", with a VOC6 of 6/7.

In phase 6, we assess how the patient's body feels. It is calm and serene. She explains that she feels strong having been through the chemotherapy wagon and overcoming the shock of the diagnosis. We close with a bilization session.



Situation	I'm at the oncologist's
Image	The doctor's hands
NC	I'm lost
PC	I am able to
VOC	2/7
Emotion	Fear
SUDs	8/10
BODY	Knotted throat
desensitisation	
SUDs	2/10
PC	I am strong
VOC	6/7
Cs	calm

Figure 5 : Rebecca's train: entrance, diagnosis, encounter, surgery, unknown carriage and exit

<sup>5</sup>With oncology patients, the number 0 is not often reached. When we work on the difficult moments of the train, the patient is always on it. We help the patient to reach a value that enables him or her to function and continue their medical journey.

<sup>6</sup>VOC: Validity of the Positive Cognition

**Session 3: work on the second most moment**

For Rebecca, this is the moment when she changes carriages.

We define with her the most disturbing situation that represents this change: "I wake up after my operation and I see my bandage".

After reprocessing, SUD was 1/10 and she spontaneously said she felt ready, and her body was serene.

We finish with a stabilisation exercise and offer Rebecca the chance to write a letter (Dellucci, 2017) to her breast for the next session. She accepts.



Figure 6 : Rebecca's train with the carriage change

Entering the train	
After desensitisation	
SUDs	2/10
PC	I am strong
VOC	6/7
Body	calm

Changing carriages	
Situation	I wake up and see my bandage
Image	I see myself in the mirror
NC	It's not me
PC	I'm ready
VOC	2/7
Emotion	Fear
SUDs	7/10
Body	I'm contracted
desensitisation	
SUDs	1/10
PC	I'm ready
VOC	7/7
Body	serene

**Session 4: the letter to the breast**

Writing a letter is a protocol from Hélène Dellucci (2017) for putting down in writing a relationship with another person. In this case, it's the relationship to the breast. The letter could also be addressed to the body or to cancer.

We review the previous session. We ask how she

feels about the operation. We assess whether there are still any disturbances.

She felt light and calm after the meeting. She talked to her friends about how she would cope with waking up and making first contact with her new body after the operation. She was able to write the letter.

**Reading the letter**

We rate Rebecca's feelings before reading (0 not at all ready, 10 ready). She says she's ready at 7/10. We discuss this and she explains that it's like mourning. We did an EMDR session on this. At the end of the session, she felt 9/10 ready.

Rebecca takes the time to read her letter in front of the therapist and each time an emotion arises, the reading is interrupted so that SBA can be set up, until the patient stabilizes. The reading resumes at the sentence read before the emotion occurs.

The reading session ends when the letter has been read in its entirety without stopping. In the case of our patient, this was the case after 2 readings.

We assess her level of disturbance at the end of

the reading. The SUD is 3/10. We ask her what 3/10 represents. She explains that she sees herself when she wakes up and wants to look and that she feels worried. We suggested continuing the SBA with this. After several SBAs, she verbalizes being fine and her SUD is at 1/10.

She explains, "I'm able to respect myself and think about myself. We install this cognition, which has a VOC of 7/7. She feels her body is calm.

She thanks us and that she verbalizes feeling ready for her operation.

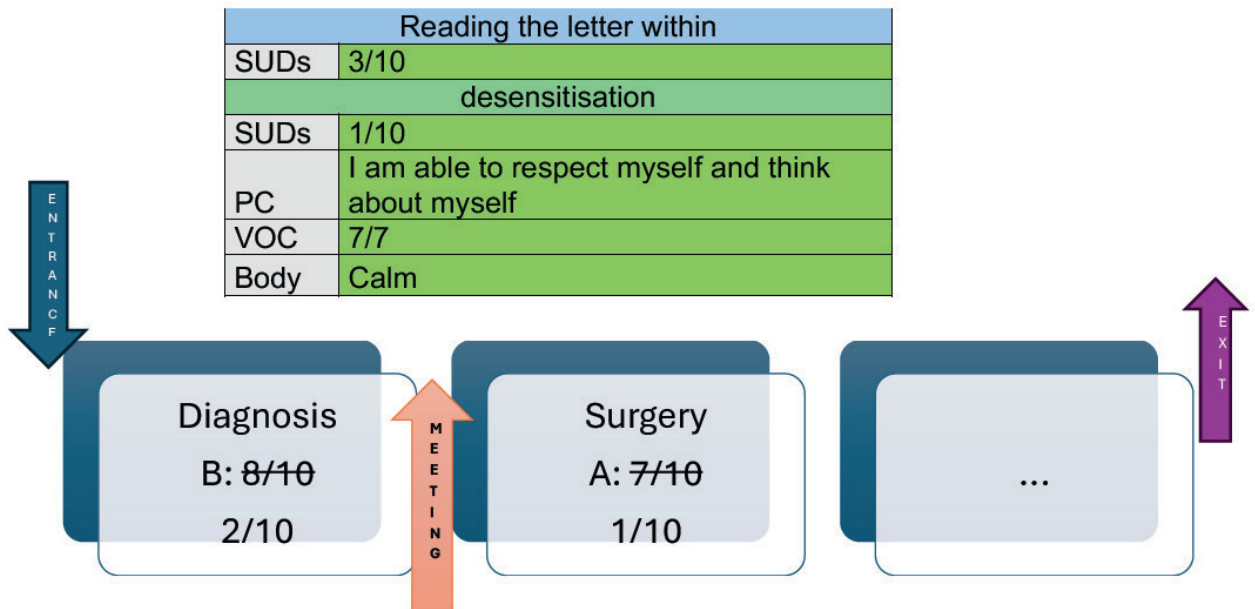


Figure 7 : Rebecca's train after the various sessions

Entering the train	
desensitisation	
SUDs	2/10
PC	I am strong
VOC	6/7

Changing carriages	
desensitisation	
SUDs	1/10
PC	I'm ready
VOC	7/7
Body	Serein

### The bouquet of flowers

We close the session with a hypnosis exercise based on the integration of different positive cognitions and bodily sensations. We call this "the bouquet of flowers". Each flower represents a positive cognition and a body sensation.

We invite patients to make up a bouquet and place it in a place that suits them. We reinforce this exercise with post-hypnotic suggestions. "When you are faced with a new situation, your consciousness will activate the necessary resources present in this bouquet." In Rebecca's case, we use "I'm strong", "I'm ready" and "I'm able to respect myself and think about myself" with the sensations of "calm and serenity".

### Session 5: Rebecca is seen after the "surgery"

She is seen post-surgery and verbalizes her feelings. She explained that she had used the flower bouquet exercise the day before her operation and woke up feeling very calm.

She decided on her own to look at her scar the next day when she returned home. She was soon able to look at herself in the mirror and touch the scars without apprehension. She is very proud of herself and her achievements.

Rebecca is awaiting the results of her operation. Depending on the results, she will be told what to do next and is beginning to plan for the end of her treatment and therefore the end of her train, and she would like to continue her psychological treatment with EMDR.

### Conclusion


EMDR enabled Rebecca to prepare for her new body by using what she had learnt since the start of her train journey, reinforcing resources with positive cognitions such as "I'm strong", "I'm ready" and "I'm able to respect myself and think about myself".

Working with the train protocol means that oncology patients can be given tailor-made support. It adapts according to how they feel about the most important disturbances. The next step will be to work on how the patient feels about the end of the train. Although we know that the presence of PTSD in oncology patients is controversial, screening remains important, along with long-term monitoring of patients and families. Symptoms of post traumatic stress disorder generally appear in the first few months following the trauma but can sometimes not appear until several months or even years later (Moshirpanahi et al., 2020; Post-Traumatic Stress Disorder and cancer, 2022). If symptoms of PTSD are present, cancer patients and survivors need psychological support. In fact, these can block patients' ability to monitor their disease (difficulty in attending medical appointments, triggered by their experience of the disease).

This is why EMDR therapy using the train protocol claims to be "innovative". It offers a different kind of support.

With this in mind, we are starting a pilot study in 2025 entitled "The impact of EMDR intervention (train protocol) on trauma in patients treated with chemotherapy for non-metastatic breast cancer: a pilot study".

The primary objective will be to evaluate the feasibility of the EMDR therapy train protocol on trauma in patients treated with chemotherapy for non-metastatic breast cancer. The secondary objectives will be to evaluate the feasibility of the intervention on emotional regulation and quality of life in patients treated with chemotherapy for non-metastatic breast cancer. This oncology train protocol can be adapted to other health conditions (cardiology, neurology, etc.).

This protocol can be taught to EMDR practitioners, via a manual currently in preparation, to train them to accompany patients in the medical field. 

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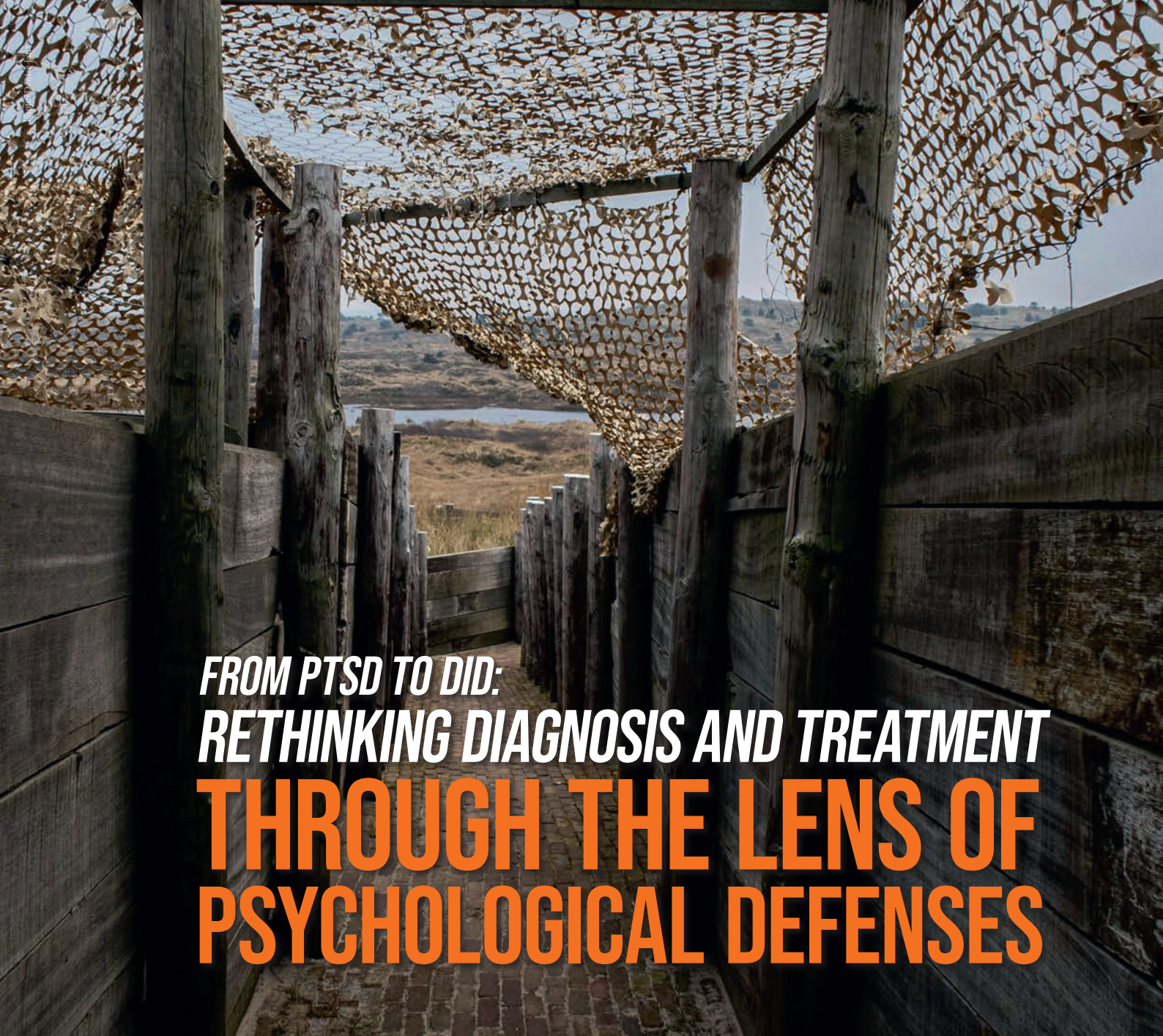
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*FROM PTSD TO DID:*  
*RETHINKING DIAGNOSIS AND TREATMENT*  
**THROUGH THE LENS OF  
PSYCHOLOGICAL DEFENSES**

By: Dolores Mosquera  
Presented at the ESTD Conference, 2025

**Understanding trauma-related disorders requires a shift from rigid diagnostic categories toward a more nuanced, defense-informed perspective.** This article explores how psychological defenses can guide both diagnostic clarity and therapeutic planning across the spectrum of trauma-related conditions—from PTSD to Dissociative Identity Disorder (DID). Drawing on EMDR therapy’s Adaptive Information Processing (AIP) model and clinical experience, we propose a framework

for recognizing how defensive processes shape symptom expression, relational functioning, and readiness for trauma work.

**EMDR Therapy and the Adaptive Information Processing Model**

EMDR therapy provides both a theoretical framework and a clinical method to address trauma-related pathology. At the core of EMDR is the Adaptive Information Processing model (AIP), which posits that the human

brain is inherently geared toward healing and integration. However, when traumatic experiences overwhelm the system, memories may be stored in a dysfunctionally isolated form—disconnected from adaptive networks and emotional regulation systems.

When memories are adaptively processed, they are integrated into one's life narrative and recalled without overwhelming affect or physical symptoms. In contrast, dysfunctionally stored memories are frozen in time. They contain the same thoughts, emotions, somatic responses, and perceptions that were present during the original event. These can later become reactivated by seemingly benign triggers, leading to disproportionate responses, negative self-perceptions, and persistent relational difficulties. Clinicians trained in EMDR therapy can use the AIP model to recognize the presence of unprocessed trauma and help clients reprocess these memories to facilitate integration and healing. Importantly, this process requires adaptation based on the client's level of dissociation, emotional regulation, and developmental history.

### **The PTSD Spectrum: Understanding the Gradient of Severity**

Rather than viewing PTSD, complex PTSD (C-PTSD), Borderline Personality Disorder (BPD), and Dissociative Disorders as separate and distinct diagnoses, we can conceptualize them along a spectrum of increasing fragmentation, emotional dysregulation, and impairment in self-structure—all of which are adaptive responses to unresolved traumatic experiences and the ways in which the mind and body attempt to cope.

Clinicians often struggle with assessing readiness for trauma processing. However, relying solely on diagnostic categories may be less helpful than exploring the protective patterns that were developed to survive—and that become activated when triggered.

Understanding these survival strategies often provides more meaningful clinical guidance than focusing narrowly on labels.

This section of the article offers a description of how clients across the trauma spectrum—including those with diverse diagnoses and clinical presentations—manage traumatic memories, and how these protective strategies interfere with or support daily functioning and internal organization.

### **Simple PTSD**

Clients with single-incident or circumscribed trauma typically present with intrusive memories, thoughts, flashbacks, and avoidance. However, they usually retain a basic capacity to distinguish past from present and understand that their symptoms stem from prior trauma. They tend to have sufficient emotional regulation and a functional sense of identity. Therapeutic alliance is generally established early, and trauma reprocessing with EMDR can commence without extensive preparation. Still, care must be taken to assess the client's window of tolerance and readiness to confront distressing memories.

### **Complex PTSD**

Clients with C-PTSD present with more pervasive symptoms, including persistent negative self-concept, affective instability, and chronic interpersonal difficulties. These individuals often experienced prolonged childhood neglect or abuse, particularly at the hands of caregivers. Triggers are both external and internal, and emotional dysregulation is common. Clients may become overwhelmed by shame, guilt, and fear, and are often highly vigilant in relationships.

In EMDR work with C-PTSD, the preparation phase becomes more crucial. Clients benefit from emotion regulation skills, psychoeducation, and resource development before initiating trauma reprocessing. Working with clusters of memories related to core beliefs or attachment wounds can yield significant therapeutic

gains. The therapist must also recognize developmental gaps in self-structure and foster adaptive information to fill in what was never developed.

Although many clients diagnosed with Borderline Personality Disorder also meet criteria for C-PTSD, their shifts in identity, heightened relational reactivity, and rapid mood swings tend to be more intense. Triggers—often interpersonal in nature—can evoke overwhelming affect and provoke intrusive or distorted beliefs about self and others' intentions.

These relational dynamics often originate in early attachment ruptures, chronic neglect, and traumatic experiences. As a result, fears of abandonment and loneliness are deeply entrenched and easily activated—often presenting as heightened relational reactivity in these clients.

In EMDR treatment, it is essential to consider the client's capacity to tolerate emotional intensity, as well as the potential use of compensatory strategies such as self-harm or episodes of disconnection. However, these risks should not automatically delay trauma work. Many clients with BPD can engage in reprocessing and actually stabilize as a result. The key lies in accurately assessing readiness, internal organization, and the presence of dissociative features.

When dissociative symptoms are more pronounced, clinicians may need to balance trauma processing with targeted resourcing and stabilization—emphasizing grounding, containment, and the gradual integration of adaptive perspectives. Toxic internal messages—such as “I am unlovable” or “I am dangerous”—should be explicitly identified and dismantled across both the preparatory and trauma-focused phases of treatment.

### **Dissociative Disorders (Non-DID)**

Clients with dissociative disorders often

experience marked disconnection from their emotions, thoughts, and sense of identity. Intrusions from dissociative parts may feel alien or confusing, and these parts—often developmentally fixated—respond to present-day stimuli as if the original danger were still occurring. Time orientation, memory continuity, and identity coherence are often significantly impaired.

Therapeutic work with these clients requires both patience and precision. Strong defensive barriers often obscure traumatic memories, making treatment planning and target identification more challenging. Clients frequently struggle to identify triggers, especially when trauma is not consciously remembered. In these cases, EMDR preparation involves gradually developing tolerance for emotional discomfort, establishing, and fostering communication with dissociative parts, and making gradual gentle connections between present-day difficulties and their historical roots. Dissociative Identity Disorder (DID)

At the most complex end of the spectrum lies DID, characterized by profound fragmentation of identity, complex inner dynamics among dissociative parts, and extensive amnesia. These dissociative parts may hold distinct autobiographical memories, affective states, and even motor patterns. Some are protective, others childlike, and some might be aggressive or mimic perpetrator behavior.

In DID, integrative capacity is often undeveloped. Treatment requires building trust with the system as a whole and fostering cooperation among dissociative parts. Trauma reprocessing cannot proceed until a foundation of basic safety, internal communication, and mutual respect has been established.

Therapists should avoid forcing realization or integration, as this can lead to phobic avoidance or escalate inner conflict. Instead, the focus

should be on helping clients gradually expand their capacity for perspective-taking, co-consciousness and adaptive functioning.

### **Psychological Defenses: A Functional Lens for Diagnosis and Treatment**

Rather than focusing solely on symptom clusters, clinicians should examine how clients use psychological defenses to cope with overwhelming affect, relational threat, and dissociative fragmentation. These defenses often reveal more about the client's internal world and treatment needs than the formal diagnosis itself. As such, understanding the function and organization of these defenses can offer deeper clinical insights—insights that are often more beneficial for treatment planning and therapeutic engagement than the diagnostic label alone.

#### **Classic Defenses**

These include denial, rationalization, minimization, and avoidance. While familiar in psychoanalytic literature, in trauma survivors they frequently serve a vital function: protecting the psyche from unbearable realizations and enabling basic daily functioning. These strategies should be viewed as adaptive responses rather than signs of resistance.

#### **Alternative Realities**

Some clients develop alternative narratives to explain their traumatic experiences, often to avoid the full emotional impact of abuse or neglect. These protective stories may include fantastical elements or compensatory beliefs—such as “I fought off my abuser,” or “My real parents will come back for me”. These narratives must not be dismantled prematurely. Instead, therapists should support the gradual development of safety and connection, allowing realization to emerge over time.

#### **Parallel Worlds**

Especially among clients who endured profound emotional neglect, rich inner fantasy worlds may

develop as protective sanctuaries. These are not psychotic delusions, but rather elaborately constructed inner spaces that reflect unmet relational needs. Clients may interact with internal characters or environments that offer comfort, structure, or escape. Therapeutic work should validate the creativity and function of these worlds, while gently supporting the client's capacity to differentiate between internal and external reality and to engage more fully in the present.

#### **Learned Identities and Constructed Characters**

For clients with Dissociative Identity Disorder or trauma-related identity confusion, identity expression may take the form of distinct roles, characters, or personas. Some of these are genuine dissociative parts with autonomous functions, while others are constructed protective roles—similar in function to parallel world constructs—developed to gain safety, acceptance, or control in threatening environments.

These protective identities may appear to function like dissociative parts, but they are often learned adaptations rather than true structural dissociation. What makes these presentations particularly challenging is that clients may focus on describing these constructed roles while avoiding contact with the more vulnerable, dissociative parts beneath them. This avoidance, though protective, can obscure the clinical picture and, if not recognized, may contribute to increased internal confusion and further fragmentation rather than integration.

The therapist's task is to approach these expressions with curiosity and respect—recognizing their adaptive purpose—while gently guiding the client toward deeper awareness, inner differentiation, and eventual engagement with the underlying dissociative experience.

Key Treatment Principles Across the Spectrum  
Effective trauma therapy across the PTSD and

dissociative spectrum requires sensitivity to internal complexity, flexibility in pacing and a relational stance that respects all aspects of the client's experience. The following principles are essential for effective trauma work:

**1. Build alliance with all parts of the person:** Clients with trauma and dissociation may present with conflicting narratives, sudden emotional shifts, or seemingly contradictory behaviors. Therapists must form an alliance not only with the presenting self but with the internal system as a whole. In cases of DID, this includes developing rapport with all the dissociative parts—especially those that are avoidant, hostile, or identify with perpetrators.

**2. Do not force realization:** For clients with relevant dissociative symptoms, constructed realities or protective identities, realization of past trauma is a gradual process. Pressuring awareness can cause retraumatization or increase avoidance. Instead, begin with psychoeducation, emotional regulation, and gentle exploration of symbolic material.

**3. Focus on function over form:** Rather than getting caught up in whether symptoms fit a certain diagnosis, examine how they function as defenses. What do the parts, beliefs, or behaviors protect against? What emotional truth would be overwhelming if fully experienced?

**4. Address toxic messages and distortions:** Clients with C-PTSD and BPD often internalize messages like “I am worthless” or “I cause harm.” These beliefs may emerge during EMDR sessions as blocking beliefs or intense affect. Actively addressing these messages is essential for healing and integration.

**5. Support adaptive identity development:** Particularly for clients with identity confusion, therapy must provide space to explore authentic self-experience. This includes helping clients move beyond learned roles or external validations. Therapists should help the client explore aspects of identity that are grounded, self-directed, and not solely defined by symptoms or diagnosis.

**6. Use metaphors and creativity:** When working with dissociative parts, parallel worlds, or symbolic constructs, metaphors can serve as powerful bridges between inner and outer realities. EMDR interventions can incorporate these metaphors to facilitate emotional access, narrative coherence, and symbolic resolution. Creativity is not just avoidance—it can also be a direct path into the client's core experience.

### **Conclusion: Seeing Beyond the Diagnosis**

In trauma therapy—particularly when working with complex dissociation—the most important diagnostic tool is curiosity. Clients are often telling us their stories, not always through words, but through symptoms, defenses, relational patterns, and silences. Our task is not to force them into diagnostic categories, but to understand the purpose behind their adaptations and support the emergence of new, more integrated ways of functioning.

By viewing clients through the lens of psychological defenses and the AIP model, we acknowledge both the suffering and the creativity that underlie trauma responses. EMDR therapy, when used with flexibility, attunement, and relational sensitivity, offers a powerful roadmap for transforming suffering into integration—fragmentation and conflict into coherence.

Thinking dimensionally—through the lens of protective survival strategies rather than diagnostic labels—guides clinicians in tailoring EMDR preparation, pacing, and target selection to each client's unique position on the trauma spectrum. True change in trauma treatment is not achieved through confrontation alone, but through connection—by seeing the person not just for what they've lived, but for who they have the capacity to become. 🌈

Book review by Marlene du Plessis

## Dissociative Identities: Attachment-based Approaches to Psychotherapy

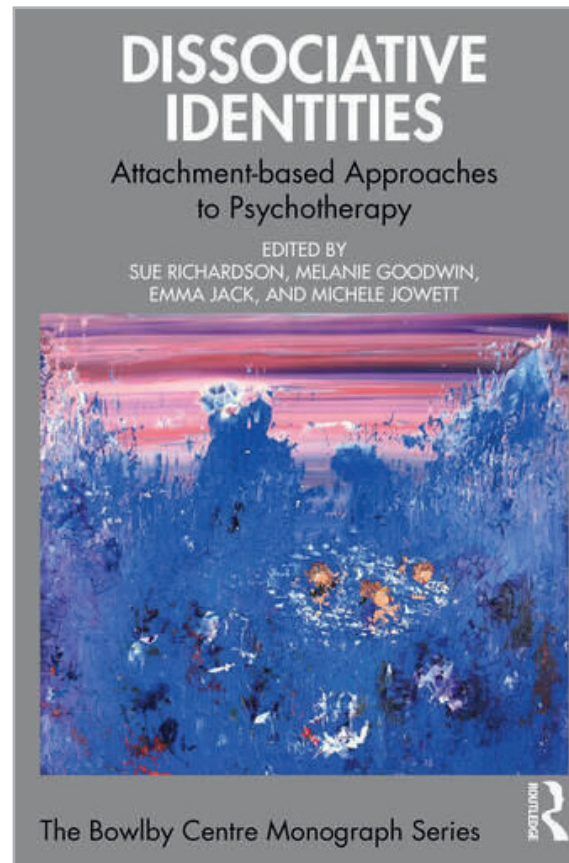
By: Sue Richardson, Melanie Goodwin, Emma Jack, Michele

Routledge, 2024  
Copyright 2025

As someone still deepening my understanding of dissociation and its therapeutic complexities, I found *Dissociative Identities: Attachment-based Approaches to Psychotherapy* to be both enlightening and accessible. This collaborative work brings together leading experts in the field, alongside powerful contributions from individuals with lived experience – not only as people living with dissociative identities, but also as recipients of therapy. Their reflections on what helped, what mattered, and what made a difference are offered back to us as therapists like a therapeutic mirror - quite thought-provoking.

The book offers a thoughtful and non-pathologising exploration of the deep links between dissociation and early attachment trauma; highlighting the relationship not just between parts and the whole, but between client and therapist.

What stood out most to me was how clearly the book presents complex theory in grounded, relatable ways. The case studies bring the material to life, providing real insight into how therapists and clients together navigate



the profound effects of trauma, the intricate dynamics working with the fragmented self and its layered inner world, and the unsettling reality that perpetrators are sometimes well-known or respected figures. I particularly valued the variety of therapeutic methods shared - from traditional talk therapy to creative, client-led approaches – all of which felt flexible, compassionate, and attuned.

One moment that stayed with me was a reflection from one of the authors about her first session with a client with Dissociative Identity Disorder. It was reassuring to hear that even experienced professionals once stood at the beginning, unsure but open. That reminder - that growth is continuous, and presence is just as important as knowledge - was encouraging.

“The Parts, the Whole, and the Real Person,” which explores the hidden attachment relationships within the internal system, stood

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out for me personally. Many of my clients often reflect on the Self and its relationship to their parts and this chapter echoed in a meaningful way. Referring to this chapter, one quote from a contributor with lived experience struck me deeply: “Thank you for giving me a voice to share my truth with the world” (p.161). That line carries both power and hope - and I join in that hope, that the world will indeed listen.

Although some of the theoretical content on attachment, attachment trauma, the impact of trauma and specifically dissociation may feel a bit overwhelming to those new to the topic, but the conversational and supportive tone throughout makes it approachable and engaging for a wide range of readers.

Overall, I found this book to be a valuable and inspiring resource. It bridges theory and practice in a way that feels deeply human, and I believe it belongs on the shelf of anyone working with complex trauma and dissociation – whether you’re just beginning or already well along in your journey. 🌈

Article review by Erik L.J.L. de Soir

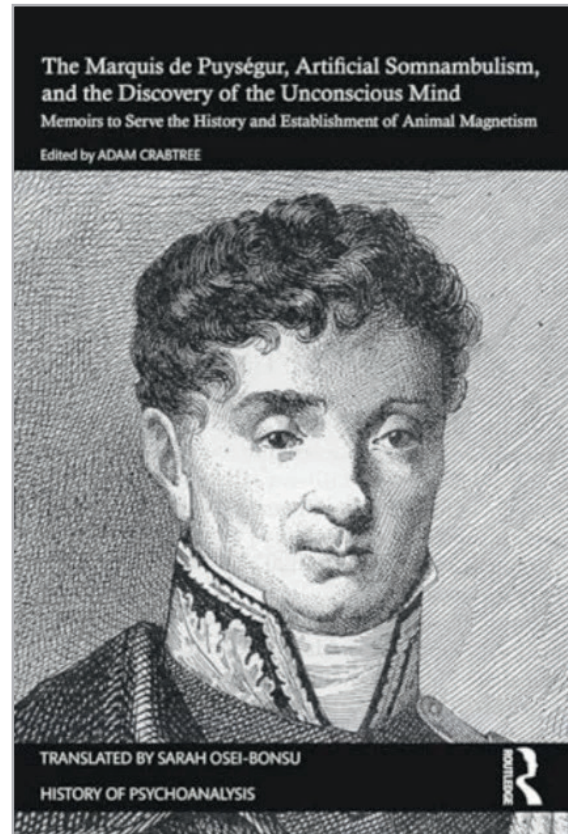
## The Marquis de Puységur, Artificial Somnambulism, and the Discovery of the Unconscious Mind

Research shows that individuals diagnosed with The Marquis de Puységur, Artificial Somnambulism, and the Discovery of the Unconscious Mind, edited and translated by Adam Crabtree and Sarah Osei-Bonsu, presents a pivotal moment in the history of psychology and psychotherapy. This volume offers the first full English translation of Puységur's 1784 memoir, *Memoirs to Serve the History and Establishment of Animal Magnetism*, a foundational text that documents the discovery of "artificial somnambulism" and its implications for understanding the unconscious mind.

In 1970 Henri F. Ellenberger already called attention to the previously unrecognized importance of Frans Anton Mesmer's 'animal magnetism' in the rise of psychodynamic psychology in the West (Crabtree, 2019) in his opus magnum, *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry*. In his new book on The Marquis de Puységur, Adam Crabtree takes the next step of tracing the course of events that led to the discovery of 'magnetic somnambulism' in a tumultuous social and political climate beginning from the secret and private publication of his first *Mémoires*.

### Historical context and significance

Armand-Marie-Jacques de Chastenot, the



Marquis de Puységur, was a French aristocrat and a prominent figure in the early development of animal magnetism, a precursor to modern hypnosis. While Franz Anton Mesmer introduced the concept of animal magnetism, it was Puységur who, in 1784, documented a novel phenomenon during his therapeutic practices. When attempting to treat his servant, Victor Race, Puységur observed that Victor entered a state of deep, peaceful sleep, during which he exhibited heightened awareness and abilities that were absent in his waking state. Puységur termed this state "artificial somnambulism"

This discovery was revolutionary. It suggested the existence of a secondary, dissociative state of consciousness that could be induced therapeutically. In this somnambulistic state, patients demonstrated abilities such as clairvoyance, diagnosis of their own illnesses, and prescient insights into their conditions—phenomena that challenged the prevailing

understanding of the mind and its faculties. In his letter to 'L'abbé L'abdan' – Father Abdan – on December 28, 1784, he wrote: ' (...) I believe it is not yet time to publish the things that I have seen, for they will be difficult to believe, even though I have attached a great number of supporting testimonies (p.1)'. This illustrates how the Marquis de Puységur wanted to keep his clinical observations and findings secret from the medical world, scared to be cursed for his practice of 'magnetism'.

The Marquis de Puységur believed in the existence of a universal fluid vivifying all of Nature and that this fluid on earth is continually in motion, and that this was a truth no less ancient and no less demonstrable till his discovery. In his opinion, doctors, by monopolizing the right to apply these discoveries to treat the sick, had proven their ignorance of the cause of these phenomena.

#### **Content and structure of the memoirs**

Puységur's memoir is a detailed account of his observations and experiences with animal magnetism. The text is methodical, documenting specific cases, including Victor's, and describing the procedures and outcomes of his treatments. Many of these 'treatments' took place at his estate, the Château de Buzancy (near Soissons in France). Puységur meticulously notes the conditions under which artificial somnambulism occurred, the behaviors exhibited by patients in this state, and the therapeutic benefits observed. The memoir is divided into sections that explore different aspects of animal magnetism, including the nature of the magnetic crisis, the role of the magnetizer, and the therapeutic applications of induced somnambulism. Puységur's writing is both empirical and reflective, offering insights into his evolving understanding of the mind and its capacities.

#### **Editorial contributions and contemporary relevance**

The editors, Adam Crabtree and Sarah Osei-Bonsu, not only translated the memoirs but

also provided valuable context for Puységur's work. Crabtree, a noted historian of psychology, introduces the concept of the "alternate-consciousness paradigm," which posits that individuals possess multiple, distinct states of consciousness. This paradigm, as demonstrated in Puységur's observations, has profound implications for understanding dissociative states and the unconscious mind. In this way, the clinical descriptions of somnambulistic trance and dissociative states provided by the Marquis de Puységur precede the important body of work of Pierre Janet.

Osei-Bonsu's contributions further illuminate the historical and cultural context of Puységur's work, situating it within the broader developments in 18th-century French science and medicine. Together, the editors underscore the significance of Puységur's discoveries in the evolution of psychodynamic thought and their enduring impact on contemporary therapeutic practices.

#### **Implications for therapy with dissociative trauma survivors**

The insights gleaned from Puységur's work have profound implications for modern therapeutic practices, particularly in the treatment of dissociative trauma survivors. The concept of artificial somnambulism aligns closely with contemporary understandings of hypnosis and dissociation, wherein individuals experience distinct, compartmentalized states of consciousness.

In therapy, recognizing and working with these alternate states can facilitate healing. For instance, in the somnambulistic state, patients may access repressed memories or emotions, providing opportunities for integration and resolution. Therapists can employ techniques that induce altered states of consciousness, akin to Puységur's methods, to help patients process traumatic experiences in a safe and controlled manner.

Moreover, Puysegur's observations of patients' abilities to diagnose their own conditions and foresee their therapeutic needs suggest that individuals possess innate resources for healing. Therapists can harness these resources by fostering a therapeutic environment that encourages self-awareness and self-efficacy.

Clinical vignettes concern cases of stomach aches, vomiting and suppression for seven years, deafness for ten years, chest pains and other (psycho) somatic disorders in which the use of – what would be called today 'hypnotic suggestion' - leads to complete recovery and cure.


The memoir also highlights the importance of the therapeutic relationship. Puysegur's rapport with his patients, particularly Victor, was instrumental in facilitating the somnambulistic state. This underscores the significance of trust, empathy, and attunement in the therapeutic process, elements that are crucial when working with trauma survivors.

### Conclusion

The Marquis de Puysegur, *Artificial Somnambulism, and the Discovery of the Unconscious Mind* is a seminal work that

bridges the gap between early psychological theories and contemporary therapeutic practices. Puysegur's meticulous documentation of artificial somnambulism provides a window into the complexities of the human mind and its capacity for dissociation and healing. The editorial contributions of Crabtree and Osei-Bonsu further enrich the text, offering historical context and theoretical frameworks that enhance its relevance to modern readers.

For clinicians working with dissociative trauma survivors, this volume offers valuable insights into the therapeutic potential of altered states of consciousness. By revisiting and integrating these early discoveries, therapists can deepen their understanding of the mind's resilience and its capacity for transformation.

The Marquis de Puysegur, *Artificial Somnambulism, and the Discovery of the Unconscious Mind* is an essential addition to the library of anyone interested in the history of psychology, the nature of consciousness, and the therapeutic process. 

### References

- Crabtree, A., & Osei-Bonsu, S. (2025). *The Marquis de Puysegur, Artificial Somnambulism, and the Discovery of the Unconscious Mind. Memoirs to Serve the History and Establishment of Animal Magnetism*. Routledge: New York. Doi: 10.4324/9781003300625
- Crabtree, A. (2019). 1784: The Marquis de Puysegur and the psychological turn in the west. *Journal of the History of Behavioral Sciences*, 1-17. Doi: 10.1002/jhbs.21974
- Ellenberger, H. (1970). *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry*. Basic Books: USA.

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# HOT OFF THE PRESS

## 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!

## Lost in the Mall? Interrogating Judgements of False Memory

Andrews, B., & Brewin, C. R.

Loftus and Pickrell's (1995) famous 'Lost in the Mall' false memory implantation experiment was recently replicated in Ireland. In this new study standard investigator judgements indicated many more false memories than did participants themselves, consistent with similar studies. We reanalysed the transcripts with investigator-judged false memories, focusing on recall of six suggested core details. On average, fewer than two details in the fake event were explicitly recalled; 20% with full and 58% with partial false memories did not recall being lost. Participants' own self-reported recall was associated with remembering more details. Half the participants described potentially true experiences, distinguishable from the fake event; this group recalled more suggested details but tended to remember them differently. The data suggested investigator ratings reflect individual comments made when participants are considering whether they remember different elements of the fake event but may not capture the way these comments are integrated in participants' own recall decisions.

Andrews, B., & Brewin, C. R. (2024). Lost in the mall? Interrogating judgements of false memory. *Applied Cognitive Psychology*, 38(6), e70012. [retrieved 07/19/2025]: <https://onlinelibrary.wiley.com/doi/10.1002/acp.70012>

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## Who Got Lost in the Mall? Challenges in Counting and Classifying False Memories

Murphy, G., & Greene, C. M.

In a reanalysis of our replication of the Lost in the Mall false memory study, Andrews and Brewin (2024) applied a novel coding scheme to count the presence of certain details in the transcripts of participants' interviews, ultimately suggesting the false memory rate was just 4% rather than 35%. We disagree with this narrow reanalysis but believe it raises important points about the constructive nature of memory as well as how we draw inferences about a memory based on a recorded conversation. As stated in our original paper, we encourage researchers to employ multiple metrics to assess and quantify false memories and not to rely on any single coding scheme—for example, two-thirds of our participants self-reported remembering (14%) or believing (52%) the fake event occurred. We also argue that even if the false memory rate was just 4%, that would still have significant theoretical and legal implications.

Murphy, G., & Greene, C. M. (2025). Who Got Lost in the Mall? Challenges in Counting and Classifying False Memories. *Applied Cognitive Psychology*, 39(2), e70044. [retrieved 07/19/2025]: <https://onlinelibrary.wiley.com/doi/full/10.1002/acp.70044>

## Using Machine Learning to Increase Access to and Engagement with Trauma-Focused Interventions for Posttraumatic Stress Disorder

Lenton-Brym, A. P., Collins, A., Lane, J., Busso, C., Ouyang, J., Fitzpatrick, S., ... & Monson, C. M.

Post-traumatic stress disorder (PTSD) poses a global public health challenge. Evidence-based psychotherapies (EBPs) for PTSD reduce symptoms and improve functioning (Forbes et al., Guilford Press, 2020, 3). However, a number of barriers to access and engagement with these interventions prevail. As a result, the use of EBPs in community settings remains disappointingly low (Charney et al., *Psychological Trauma: Theory, Research, Practice, and Policy*, 11, 2019, 793; Richards et al., *Community Mental Health Journal*, 53, 2017, 215), and not all patients who receive an EBP for PTSD benefit optimally (Asmundson et al., *Cognitive Behaviour Therapy*, 48, 2019, 1). Advancements in artificial intelligence (AI) have introduced new possibilities for increasing access to and quality of mental health interventions.

Lenton-Brym, A. P., Collins, A., Lane, J., Busso, C., Ouyang, J., Fitzpatrick, S., ... & Monson, C. M. (2025). Using machine learning to increase access to and engagement with trauma-focused interventions for posttraumatic stress disorder. *British Journal of Clinical Psychology*, 64(1), 125-136. [retrieved 07/19/2025]: <https://bpspsychub.onlinelibrary.wiley.com/doi/full/10.1111/bjc.12468>

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## Selected Aspects of Diagnosis and Therapy in Dissociative Identity Disorder (DID)—Case Report

Orlof, W., Sołowiej-Chmiel, J., & Waszkiewicz, N.

**Introduction:** Dissociative identity disorder (DID) is a condition characterized by the presence of at least two distinct identities. The experience of severe trauma, particularly in childhood and especially related to physical and emotional abuse, is considered the most common etiological source, leading to the development of dissociative mechanisms, as confirmed by both the literature and the authors' research findings. The diagnosis of DID is complex and requires a multimodal approach. This report presents a comprehensive psychiatric and psychological assessment using an integrated diagnostic framework combining clinical observation, psychometric evaluation, and neuroimaging.

**Methods:** A 33-year-old woman presented to the Psychiatric Clinic due to numerous amnesic episodes and recurrent identity switches, resulting in a lack of continuity in autobiographical memory and heterogeneous functioning. The patient had previously been treated at the Mental Health Outpatient Clinic with suspected schizophrenia. The patient's history was difficult to collect and switches between identities were observed, with a marked change in behavior. The patient declared the presence of 46 different personalities. The stories she reported changed, depending on the dominant identity, each of which varied in terms of gender, name, sexual orientation, interests, or pattern of behavior.

**Results:** The patient underwent a thorough laboratory diagnosis, including toxicologic diagnosis, neuroimaging, and psychological diagnosis. On the basis of the information collected, based on the ICD-10 Classification, the diagnosis was: F44.8—dissociative identity disorder.

**Discussion:** The clinical entity described by the authors still poses many diagnostic and therapeutic uncertainties. In the literature, we do not find a case description that holistically encompasses DID. Therefore, the following description represents a unique bibliographic item that is useful to professionals in planning medical and therapeutic care.

Orlof, W., Sołowiej-Chmiel, J., & Waszkiewicz, N. (2025). Selected Aspects of Diagnosis and Therapy in Dissociative Identity Disorder (DID)—Case Report. *Journal of Clinical Medicine*, 14(8), 2617. [retrieved 07/19/2025]: <https://www.mdpi.com/2077-0383/14/8/2617>

## Neuroscience-Based Relational Art Therapy and Deep Brain Reorienting in the Treatment of Dissociative Identity Disorder

Gerge, A., Rudstam, G., & Söndergaard, H. P.

Art therapy (AT) has been proposed as a treatment for post-traumatic conditions, potentially by providing somatic sensory input that can (i) enhance the client's sense of self and embodiment,

(ii) modulate arousal, and (iii) aid in rethinking and reframing traumatic memories. However, evidence supporting AT as a treatment for dissociative disorders remains limited. The theoretical basis for the efficacy of AT is discussed in relation to findings regarding the traumatized person's brain and mindset, as well as its altered functional network connectivity. It is crucial to consider specific alterations in brain networks associated with trauma, particularly those occurring in the deep brain regions, which include the midbrain, the brainstem, and the cerebellum. The hypothesis suggests that early or severe trauma can impair the brain's higher regulatory functions, as explained by the cascade theory. This theory explains how diverse activation patterns within the midbrain's periaqueductal gray (PAG) of the midbrain influence the limbic system and cortices, thereby modulating states of being and behavior. Phase-specific, resource-oriented, and long-term therapy for complexly traumatized and dissociative individuals can benefit from novel insights from neuroimaging studies to inform and enhance therapeutic methods. This is illustrated in a clinical vignette with a client diagnosed with dissociative identity disorder (DID), where deep brain reorienting (DBR) was combined with relational AT. The AT component is hypothesized to have facilitated a sense of grounding in the present moment and enhanced the client's access to her neurophenomenological self. Moreover, changes may have occurred at implicit and non-verbal levels. DBR is believed to have helped the client remain present with her previously avoided and unbearable internal experience. To validate these assumptions, the second author conducted a semi-structured interview that focused on the client's experiences of being dissociative and in psychotherapy, including the effect of DBR when introduced after AT. The client's experiences were articulated through a thematic analysis of the interview, which yielded the following themes: Loneliness, getting help, and moving towards togetherness. Further research on and development of therapy methods that enhance the neuroplasticity necessary for highly dissociative clients to change and heal are highly recommended.

Gerge, A., Rudstam, G., & Söndergaard, H. P. (2025). Neuroscience-based relational art therapy and deep brain reorienting in the treatment of dissociative identity disorder. *Frontiers in Psychology*, 16, 1454483. [retrieved 07/19/2025]: <https://www.frontiersin.org/journals/psychology/articles/10.3389/fpsyg.2025.1454483/full>

## Maternal Oxytocin Administration Mitigates Nociceptive, Social, and Epigenetic Impairments in Adolescent Offspring Exposed to Perinatal Trauma

Harris, S., Kodila, Z., Salberg, S., Sgro, M., Vlassopoulos, E., Li, C. N., ... & Mychasiuk, R.

Adverse childhood experiences (ACEs) alter brain development, leading to vulnerability for chronic pain, mental health disorders, and suicidality. These effects often emerge during adolescence. Importantly, ACEs can occur prenatally, including when exposed to in utero intimate partner violence (IPV) or postnatally as maternal neglect. Maternal social support has demonstrated promise in the mitigation of ACE-related deficits. Oxytocin, which has a role in social-bonding and stress regulation, serves as a suitable surrogate for social support in preclinical studies. Therefore, we aimed to

explore the effects of oxytocin on alleviating social deficits, nociception, and epigenetic changes resulting from the hat aimed to mimic the stress normally induced following exposure to the ACEs: IPV in utero and maternal neglect. During pregnancy, dams were randomly assigned to experience the model of IPV or a sham insult. Following birth, offspring from the IPV group underwent 10 days of maternal separation. Dams received three days of oxytocin therapy while nursing. In adolescence, half of the offspring underwent plantar surgery to induce pain. Overall, in adolescence, rats exposed to the ACEs exhibited increased nociceptive sensitivity and aberrant social interactions, particularly among males, further suggesting that ACEs can increase an individual's risk for chronic pain. The ACEs changed gene expression related to social behaviour and neuroplasticity. Maternal oxytocin normalized pain, social, and gene changes, while oxytocin levels in offspring correlated with nociceptive sensitivity. Although ACEs have enduring consequences, the outcomes are modifiable, and oxytocin may be a robust and implementable therapeutic capable of attenuating early adversity.

Harris, S., Kodila, Z., Salberg, S., Sgro, M., Vlassopoulos, E., Li, C. N., ... & Mychasiuk, R. (2025). Maternal oxytocin administration mitigates nociceptive, social, and epigenetic impairments in adolescent offspring exposed to perinatal trauma. *Neurotherapeutics*, e00598. [retrieved 07/19/2025]: <https://www.sciencedirect.com/science/article/pii/S1878747925000765>

## Complex PTSD and Identification With the Aggressor Among Survivors of Childhood Abuse

Lahav, Y., Cloitre, M., Hyland, P., Shevlin, M., Ben-Ezra, M., & Karatzias, T.

**Background:** Childhood abuse (CA) is a risk factor for trauma-related disorders including posttraumatic stress disorder (PTSD) and complex posttraumatic stress disorder (CPTSD). This severe form of interpersonal trauma may result in "identification with the aggressor" (IWA), in which the individual may take on the beliefs, perspectives, and behaviors of the perpetrator. Although previous evidence suggests that IWA may be particularly related to CPTSD as compared to PTSD, there has been no study that investigated this hypothesis.

**Objective:** The current study explored the relations between IWA and PTSD and CPTSD symptoms, and the contribution of IWA to the excess probability of PTSD and CPTSD classifications, as compared to no classification.

**Participants and setting:** This cross-sectional study was conducted among 320 Israeli adult CA survivors aged 21–63 ( $M = 42.04$ ,  $SD = 10.81$ ).

**Methods:** An online survey was completed by a convenience sample of adult CA survivors.

**Results:** Replacing one's agency with that of the perpetrator as part of IWA had a significant effect on both PTSD and CPTSD symptoms ( $ES = 0.36$  and  $0.24$ , respectively), and served as a risk factor for both PTSD and CPTSD classifications. Moreover, analysis of the models' predicted values reveals that the predicted probability of CPTSD classification was 3 to 5 times higher than on the probability of PTSD classifications, for low to high values of the replacing one's agency scale, respectively.

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Conclusions: The current findings suggest that IWA may describe some of the deep and long-lasting detriments of CA on self, and may contribute to the development of CPTSD symptoms.

Lahav, Y., Cloitre, M., Hyland, P., Shevlin, M., Ben-Ezra, M., & Karatzias, T. (2025). Complex PTSD and identification with the aggressor among survivors of childhood abuse. *Child Abuse & Neglect*, 160, 107196. [retrieved 07/19/2025]: <https://www.sciencedirect.com/science/article/abs/pii/S0145213424005891>

## Attention-Deficit/Hyperactivity Disorder and Post-Traumatic Stress Disorder Adult Comorbidity: A Systematic Review

Magdi, H. M., Abousoliman, A. D., Lbrahim, A. M., Elsehrawy, M. G., El-Gazar, H. E., & Zoromba, M. A.

Background: Both attention-deficit hyperactivity disorder (ADHD) and post-traumatic stress disorder (PTSD) are complicated illnesses that sometimes co-occur in children and adults with significant negative influence on a person's life and general well-being.

Aim: This study aims to conduct a systematic review that investigates the comorbidity of PTSD and ADHD in the adult population.

Methods: A comprehensive search was conducted across five electronic databases (PsycNET, Cochrane, PubMed, Google Scholar, and ClinicalTrials.gov) between October 5 and 20, 2023, using predefined keywords including "ADHD," "PTSD," and "comorbidity." Studies were included if they involved adult participants ( $\geq 18$  years) with both ADHD and PTSD diagnoses. Two independent reviewers conducted screening and data extraction. No meta-analysis was performed due to heterogeneity in study designs. The results were synthesized qualitatively.

Results: Out of 818 identified studies, 21 met the inclusion criteria. Studies reported an increased risk of developing PTSD in individuals with ADHD, with the prevalence of comorbidity ranging between 28 and 36%. ADHD in PTSD patients was associated with greater psychosocial impairment, more severe PTSD symptoms, and functional difficulties. Treatment approaches, including pharmacotherapy (atomoxetine, Vyvanse) and mindfulness training, showed potential benefits for managing comorbid symptoms.

Conclusions: ADHD and PTSD commonly co-occur in adults, leading to more severe clinical outcomes. Early diagnosis and effective treatment of ADHD may reduce the risk of developing PTSD. Further research is needed to explore the underlying mechanisms and optimal treatment strategies for individuals with ADHD/PTSD comorbidity.

Magdi, H. M., Abousoliman, A. D., Lbrahim, A. M., Elsehrawy, M. G., El-Gazar, H. E., & Zoromba, M. A. (2025). Attention-deficit/hyperactivity disorder and post-traumatic stress disorder adult comorbidity: a systematic review. *Systematic Reviews*, 14(1), 41.

[retrieved 07/19/2025]: <https://link.springer.com/article/10.1186/s13643-025-02774-7>

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## Trauma, Epigenetic Alterations, and Psychotherapy

**Nohesara, S., & Alfonso, C. A.**

Psychotherapy was until recently described from a biological standpoint as causing structural changes in the brain and physiological alterations of neurotransmission pathways. Current research recognizes that psychotherapy also causes changes at the level of the DNA, with alterations in epigenetic mechanisms that correlate with symptom reduction and treatment response. The authors provide a brief overview of the evolving research in epigenetics, highlighting the association between trauma, DNA methylation patterns of specific gene regions, and psychiatric disorders. They also review several studies that show that various evidence-based psychotherapy interventions recalibrate these DNA methylation abnormalities. Finally, they identify studies that measured DNA methylation of BDNF and HTR3A genes and suggest that these may serve as biological markers of response to psychotherapy.

Nohesara, S., & Alfonso, C. A. (2025). Trauma, Epigenetic Alterations, and Psychotherapy. *Psychodynamic Psychiatry*, 53(2), 143-150. [retrieved 07/19/2025]: <https://guilfordjournals.com/doi/abs/10.1521/pdps.2025.53.2.143>

## Research Impacting and Involving Autistic Adults Should Be Trauma Informed

**Steehan, S. L., Ancona, L., Giwa Onaiwu, M., Brophy, K., Brown, L. X., & Taylor, S. C.**

The autism research field to date has yet to widely adopt trauma-informed thinking and practices. Since most autistic adults have a history of experiencing trauma, the field must shift to center trauma in the design of research for this population. This article calls for widespread integration of trauma-informed strategies into existing research practices focused on autistic adults. We present a summary of trauma sources across research domains and make recommendations for how to integrate existing research related to trauma experienced by autistic adults and trauma-informed practices in the current research landscape. With trauma-informed modifications to research practices, we suggest that accessibility of participation in research for autistic adults with a history of trauma will be improved and that potential trauma-related harms of research will be reduced. Additionally, considering trauma more widely as a potential modifier of autism domains including social functioning, sensory sensitivity, self-soothing behaviors, cognitive functioning, and autonomic arousal may lead to a more comprehensive understanding of these areas. Taken together, we believe that adopting trauma-informed research approaches will lead to more meaningful, impactful research.

Steehan, S. L., Ancona, L., Giwa Onaiwu, M., Brophy, K., Brown, L. X., & Taylor, S. C. (2025). Research Impacting and Involving Autistic Adults Should Be Trauma Informed. *Autism in Adulthood*. [retrieved 07/19/2025]: <https://www.liebertpub.com/doi/full/10.1089/aut.2023.0200>

## From Mistrust to Malice: Examining the Influence of Adverse Childhood Experiences on Reactive and Appetitive Aggression in Male Forensic Psychiatric Patients with a History of Drug Abuse Through the Lens of Psychodynamic Personality Structures

Fritz, M., Flad, S., Streb, J., & Dudeck, M.

Adverse childhood experiences (ACEs) represent one of the most critical factors contributing to the manifestation of psychiatric disorders later in life. Furthermore, such experiences are often associated with deficits in interpersonal relationships, manifesting as mistrust and violent behaviors, and are indicative of a fragmented personality. This study aimed to analyze the correlative relationships between personality deficits influenced by ACEs and the expression of reactive and appetitive aggression using self-report questionnaires in 53 male forensic psychiatric patients with a drug dependency background detained under §64 of the German Criminal Code between 2019 and 2022. Instruments included the Operationalized Psychodynamic Diagnosis Structure Questionnaire (OPD-SF), the Maltreatment and Abuse Chronology of Exposure Scale–German Version (KERF), and the Appetitive and Facilitative Aggression Scale (AFAS). Specifically, the OPD-SF used the following subscales: self-perception, self-regulation, the regulation of object relations, emotional communication inward/outward, internal/external attachment, and total score. The results demonstrate a significant relationship between childhood traumatic experiences, personality structure, attachment capacity, self-perception, and regulation and the expression of both reactive and appetitive aggression. While the association with reactive aggression is intuitively plausible, the findings notably reveal that the propensity to derive pleasure from violence is also associated with personality deficits caused by adverse childhood experiences. These findings have important implications for the treatment of offenders with personality disorders and should be considered in therapeutic interventions.

Fritz, M., Flad, S., Streb, J., & Dudeck, M. (2025). From Mistrust to Malice: Examining the Influence of Adverse Childhood Experiences on Reactive and Appetitive Aggression in Male Forensic Psychiatric Patients with a History of Drug Abuse Through the Lens of Psychodynamic Personality Structures. *Behavioral Sciences*, 15(3), 246. [retrieved 07/19/2025]: <https://www.mdpi.com/2076-328X/15/3/246>

## Does Shame Mediate the Influence of Trauma on Psychosis? A Systematic Review and Meta-Analytic Structural Equation Modelling Approach

Davies, K., Lappin, J. M., Briggs, N., Isobel, S., & Steel, Z

Background: Meta-analytic evidence has linked shame separately to both potentially traumatic events (PTEs) and psychosis, but the influence of shame on the relationship between PTEs and psychosis has not yet been examined. This study used meta-analytic structural equation modelling (MASEM) to examine whether shame plays a mediatory role between PTEs and experiences of psychosis.

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**Methods:** A nested search was conducted within a previous systematic review on psychosis and shame to identify articles that contained a measure of PTEs. Included studies reported a quantitative association between psychosis and shame, and additionally a quantitative relationship between either i) PTEs and psychosis; or ii) PTEs and shame.

**Findings:** Of the 40 articles initially included, 14 met criteria and 13 were included in the analyses. Overall, shame partially mediated the relationship between PTE's and psychosis, observed through a significant indirect effect ( $\beta = 0.15$ , 95 % CI: 0.11–0.19) and a reduction in the direct path that remained significant ( $\beta = 0.13$ , 95 % CI: 0.06–0.20). Indirect paths through shame between childhood PTEs and psychosis ( $\beta = 0.07$ , 95 % CI: 0.03–0.11), and between lifespan PTEs and psychosis ( $\beta = 0.09$ , 95 % CI: 0.03–0.11), were both small but significant. Both direct paths remained significant, suggesting that shame acts as a partial mediator for both types of PTE.

**Conclusions:** Shame is one path through which potentially traumatic events may influence the experience of psychosis and should be considered alongside other affective types in future modelling of psychosis. Qualitative research may aid further understanding of the mechanisms by which shame operates in this relationship.

Davies, K., Lappin, J. M., Briggs, N., Isobel, S., & Steel, Z. (2025). Does shame mediate the influence of trauma on psychosis? A systematic review and meta-analytic structural equation modelling approach. *Schizophrenia research*, 275, 87-97. [retrieved 07/19/2025]: <https://www.sciencedirect.com/science/article/pii/S0920996424005048>

## Participation, Partnership, and Sharing: Young Women's Suggestions Regarding Social Work Practices with Adolescent Girls in the Context of Youth Welfare and Care

**Shimei, N.**

**Background:** Despite the widely recognized importance of involving children and youth in shaping practices that impact their lives, translating their participation from principle into effective practice remains challenging.

**Objective:** This article explores the significance of professional practices that promote participation, partnership, and sharing in addressing the challenges of neglect, violence, and harm among adolescent girls. The study aimed to conceptualize the practices that can assist social workers in supporting adolescent girls.

**Methods:** This article presents the outcomes of a participatory action research study with young women who had experienced the welfare system as adolescents concerning social work practices with girls and young women.

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**Participants and setting:** In-depth interviews were conducted with 25 Israeli women aged 18 to 29 who grappled with hardship, distress, poverty, and social exclusion and received various forms of support from social workers during their adolescent years. Many endured physical, emotional, or sexual violence at home or in out-of-home placements and were subjected to bullying in their school environments.

**Results:** The analysis revealed that the ability of a girl or young woman to be active in the care process and exercise her right to participate in decision making concerning her life depends on the social worker's proactivity, which is expressed in three ways: participation, partnership, and sharing in the care process.

**Conclusions:** The implications of these findings in the context of youth care show the potential of these practices to foster the development of adolescent girls as active citizens.

Shimei, N. (2025). Participation, partnership, and sharing: Young women's suggestions regarding social work practices with adolescent girls in the context of youth welfare and care. *Child Abuse & Neglect*, 162, 107062. [retrieved 07/19/2025]: <https://www.sciencedirect.com/science/article/abs/pii/S0145213424004526om/doi/full/10.1080/09658211.2024.2418768>

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**Dissociation in Children & Adolescents Assessment & Treatment**

Assessment and treatment of children and adolescents with complex trauma and dissociation.  
Online training, including monthly group supervision with Dr Renée Potgieter Marks.

<https://www.integratefamilies.co.uk/dcat>

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