

EUROPEAN SOCIETY FOR TRAUMA AND DISSOCIATION
FIRST CONFERENCE 2008



G. H. Breitner, Rijksmuseum Amsterdam

**Chronic traumatization:
Disrupted attachment
and the dissociative mind**

Program and Abstract Book

Program and Abstract Book

**FIRST BI-ANNUAL INTERNATIONAL
CONFERENCE
ESTD CONFERENCE 2008**

*CHRONIC TRAUMATIZATION: DISRUPTED
ATTACHMENT
AND THE DISSOCIATIVE MIND*

APRIL 17-19, 2008

**MÖVENPICK HOTEL
AMSTERDAM, THE NETHERLANDS**

European Society for the Study of Trauma and Dissociation

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Welcome Letter From Suzette Boon To Conference Delegates

It gives me enormous pleasure, as President of the European Society for Trauma and Dissociation, to be able to welcome you all to our first annual conference here in Amsterdam.

I am also delighted to be able to announce that this conference has reached our planned maximum number of delegates, over 450 coming from 17 European countries and several continents. The five preconference workshops are also very well attended.

Since our inaugural meeting in July 2006, The ESTD Board has worked hard to bring to this organisation a culture, philosophy and professionalism that befit this increasingly recognised mental health field.

It is apt that our first annual conference should be in Amsterdam as the Dutch were among the early pioneers in Europe. They hosted the first two international conferences on Dissociation at the time in collaboration with the International Society for the Study of Dissociation (now ISSTD) in 1992 and 1995.

From the very start, ESTD has been determined to encourage the development of the study and treatment of Trauma and Dissociation across the whole of Europe and especially the immerging eastern European countries. Our fee structure reflects the present reality of inequality in incomes.

We continue to have a strong and close collaboration with ISSTD and have established a unique arrangement offering joint membership of ESTD/ISSTD to all ESTD members. We hope that those of you who have not joined us as members will feel inspired by this meeting to do so.

Conferences are as much about networking as they are about learning and sharing of knowledge. This is a unique opportunity to meet delegates from other countries as well as your own.

ENJOY THE CONFERENCE

Suzette Boon, PhD
President, European Society for Trauma and Dissociation (ESTD)

Welcome From The Program Committee

Dear Colleagues,

Welcome to the First Bi-Annual Conference of the European Society for Trauma and Dissociation in Amsterdam. The theme for the conference is “Chronic Traumatization: Disrupted Attachment and the Dissociative Mind.” Whether you are a clinician, a scientist, or both, you will find this topic of great interest.

The goal of this meeting is to enlarge our scientific and clinical understanding of chronic traumatization, including its dissociative nature, with a special emphasis on the role of attachment trauma. We seek to continue to integrate diverse findings from a wide variety of fields as we develop an increasingly sophisticated understanding of the impact of chronic traumatization. Thus, biopsychosocial aspects of chronic traumatization will be discussed from a wide variety of perspectives, to the end of enhancing more effective treatment for those who have been chronically abused and neglected as children, or have been profoundly affected by other forms of severe traumatization.

The conference highlights many exciting workshops, symposia, paper sessions, and five plenary presentations. The plenaries include the Pierre Janet Memorial Lecture, in recognition of Janet’s profound groundwork for our understanding and treatment of the psychological sequelae of chronic childhood traumatization. This year Bessel van der Kolk will deliver the Pierre Janet Memorial Lecture, with the title of “120 Years of Dissociation: A History of Brilliant Insights, Lost Awareness and Stunning Disconnections.” The other plenaries include the following: Ellert Nijenhuis: “Dissociation and the Dissociative Disorders in Europe: Theoretical, Scientific, and Clinical Advancements;” Karlen Lyons-Ruth: “From Infant Attachment Disorganization to Adult Dissociation;” Martin Teicher: “Neurobiological Consequences of Childhood Maltreatment;” and Onno van der Hart: “Structural Dissociation of the Personality: The Key to Understanding Chronic Traumatization and Its Treatment.” A plenary panel discussion on the theory of structural dissociation of the personality concludes the meeting.

We want to extend a special welcome to presenters, who come from all over the world: Australia, Belgium, Canada, Finland, France, Germany, Iran, Israel, Italy, the Netherlands, Norway, Russia, Slovakia, Spain, Sweden, Turkey, the United Kingdom, and the United States. We hope that you will find this meeting an informative and interesting opportunity to join an exciting exchange of clinical experiences, theoretical approaches and scientific developments, and we look forward to receiving your comments and feedback.

Sincerely,

Onno van der Hart, Chair, Program Committee
Suzette Boon, Program Committee
Nel Draijer, Program Committee
Ellert Nijenhuis, Program Committee

Recommendation Board

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Former Dutch Secretary of State for Social Affairs and Labour & Emancipation of Women, former Minister of Health and Welfare, and former Member of the European Parliament.

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Professor and Chair Biological Psychiatry UMC University of Groningen

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Professor University of Utrecht

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Professor of Psychiatry, AMC / University of Amsterdam

Judith L. Herman, MD, psychiatrist

Clinical Professor of Psychiatry at Harvard Medical School & Director of Training at the Victims of Violence Program at Cambridge Health Alliance.

Rolf J. Kleber, PhD, psychologist

Professor of Psychotraumatology, University of Utrecht.

Bessel A. van der Kolk, MD, psychiatrist

Professor of Psychiatry, Boston University Medical School & Medical Director of the Trauma Center at HRI Hospital in Brookline, Massachusetts

Ulrich Schnyder, MD, psychiatrist

Professor of Psychiatry University Hospital, Zürich

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Emeritus Professor of Child Psychology, University of Utrecht

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Department of Child and Adolescent Psychiatry, The National Hospital, Oslo, Norway

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Clinical Professor of Psychiatry at Harvard Medical School & Director of Training at the
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Ulrich Schnyder, MD, psychiatrist

Professor of Psychiatry
University Hospital, Zürich, Switzerland

Program committee

Suzette Boon, PhD, Zeist - *President ESTD*

Onno van der Hart, PhD, Amsterdam - *Conference Chair*

Nel Draijer, PhD, Amsterdam

Ellert Nijenhuis, PhD, Assen

Aartjan Beekman, MD, PhD, Amsterdam

Frits Boer, MD, PhD, Amsterdam

Conference Organization

Secretariat of the First Bi-Annual International Conference
ESTD Conference 2008
c/o The Congress Organisation of the AMC
P.O. Box 23213
1100 DS AMSTERDAM
The Netherlands
Tel.: +31 (0)20 5668585
Fax: +31 (0)20 6963228
E-mail: estd@amc.nl

Accreditation

CME points have been granted for Dutch participants only to the following associations:

- Nederlands Instituut voor Psychologen (NIP): requalification primary clinicians, ESTD (Pre-)conference: 10 contact hours.
- Federatie van Gezondheidszorgpsychologen (FGzP): requalification clinical psychologists and requalification GZ psychologists ESTD (Pre-)conference 20 contact hours.
- Eye Movement Desensitization and Reprocessing (EDMR) association ESTD Pre-conference: 6 contact hours and the Conference 14 contact hours.
- Nederlandse Vereniging voor Psychiatrie (NVvP): psychiatry ESTD (Pre-)conference 20 contact hours.

CME points have been applied for Dutch participants only to the following associations:

- Vereniging voor Gedragstherapie en Cognitieve Therapie (VGCT): behaviour and cogitative psychologists

General Information

Date and Location

The ESTD conference 2008 will take place from 17-19 April, 2008 in the Mövenpick Hotel Amsterdam City Centre, Piet Heinkade 11, 1019 BR Amsterdam, The Netherlands.

Language

The official language of the conference is English.

Simultaneous translations of the plenaries from English into German and French

As a service to colleagues who would prefer to hear the key note lectures at the conference in German or French, we provide simultaneous translations of these events in both German and French. We will also try to arrange simultaneous translations in these two languages for a selection of the other conference presentations. The cost of this service is only 30 Euro per participant, to be arranged during the registration.

Registration desk

The registration desk will be located in the Mövenpick Hotel Amsterdam City Centre, opening times:

Thursday April 17	08.30 – 09.30 hrs. (Pre conference workshops)
Thursday April 17	18.00 – 21.00 hrs.
Friday April 18	08.00 – 17.30 hrs.
Saturday April 19	08.30 – 16.30 hrs.

Badges

Upon registration you will receive a personal badge and other conference information. We kindly ask you to wear your badge during the whole meeting.

Telephone / messages

The telephone number of the registration desk: 020 – 5191280. Messages for participants will be displayed on the notice board next to the registration desk.

Coffee, tea and lunch

Coffee and tea will be served in the foyer during breaks (free) for all the participants of the conference.

Lunch will be served in the foyer and in the restaurant. Due to a limited number of places in the restaurant, the organising committee decided the following:

Participants with a red ticket are allowed to enter the restaurant for lunch on Friday and participants with a green ticket are allowed to enter the restaurant for lunch on Saturday. Please note that you are requested to hand in your ticket at the beginning of the restaurant.

Speakers

Speakers are requested to put their presentation (brought on USB stick or CD rom) by themselves on the laptop in the lecture room, at least one hour before the session will take place (only during the breaks). If needed a technician will be available.

Hotel accommodation

Through the intermediary of the RAI Hotel & Travel Services, hotel accommodation can be reserved. All requests can be directed to:

RAI Hotel & Travel Services

P.O. Box 77777

1070 MS Amsterdam

The Netherlands

Phone: 020 549 1927

Fax: 020 646 2840

Or contact Amsterdam Tourism & Convention Board

(Call center) phone number: 020 551 2525

E-mail: info@atcb.nl

Liability

The Conference organisation cannot be held responsible for damage, loss or theft during the conference.

Weather

In April, Amsterdam usually enjoys pleasant spring weather. Expect day temperatures between 12 – 16 °C. Evenings can be cool and there is always an unpredictable chance of rain.

Social Program

Friday April 18, 2008

19.30 – 21.30 hrs. Conference dinner

Candle light dinner on boats through the canals of Amsterdam

Fee: € 75,- per person

Please note: only participants with an admission card will be admitted to the dinner (this card will be handed out during the registration to all participants who registered for the dinner)

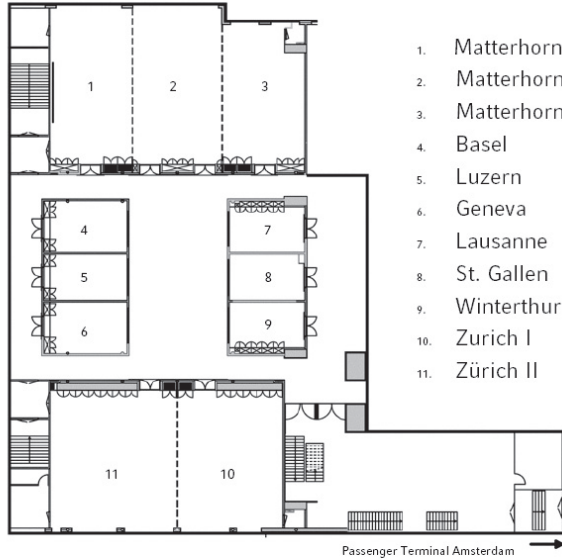
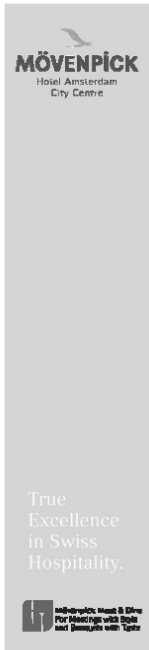
Unfortunately, on site registrations for the dinner cannot be guaranteed

City Map Of Amsterdam



Floor Plan Mövenpick Hotel

First Floor



Third Floor

The “Monta Rosa” is located on the Third floor. If you leave the elevator on the Third floor, please go to the left (and follow the signs).

Schedule at a glance

ESTD 2008 Program at a glance						
Pre conference chair	Matterhorn 1	Matterhorn 2	Matterhorn 3	Zurich 1	Zurich 2	
	Nel Draijer (p.1)	Anne Suokas-Cunliffe (p.2)	Kathy Steele (p.3)	Fran Waters (p. 4)	Pat Ogden (p.5)	
Thursday, April 17 18:00-19:30 Registration open						
19:30-21:40 Opening conference – Matterhorn 1-2-3						

Friday, April 18	Matterhorn 1	Matterhorn 2	Matterhorn 3	Zurich 1	Zurich 2	Winterthur	St. Gallen	Monta Rosa
09:00-10:30 Plenary								
10:30-11:00 Coffee/Tea Break								
11:00-12:30	Invited workshop 1 p. 11	Workshop 4 p. 14	Invited symposium p. 15	Paper session p. 19-22	Paper session p. 23-26	Workshop 2 p. 12	Research symposium p. 27-30	Workshop 3 p. 13
12:30-13:45 Lunch break								
13:45-15:15	Workshop 5 p. 31	Workshop 9 p. 35	Symposium p. 36-40	Paper session p. 41-44	Workshop 8 p. 34	Workshop 6 p. 32	Workshop 7 p.33	Paper session p. 45-48
15:15-15:45 Tea/Coffee Break								
15:45-17:15	Workshop 10 p. 49	Workshop 12 p. 51	Workshop 13 p. 52	Invited research symposium p. 53-57	Paper session p.58-60	Concurrent paper session p.61-64	Paper session p. 65-68	Workshop 11 p. 50
17:30-18:30 Annual General Meeting of ESTD								
19:30-21:30 Candle-light dinner on boat through canals								

Saturday, April 19	Matterhorn 1	Matterhorn 2	Matterhorn 3	Zurich 1	Zurich 2	Winterthur	St. Gallen	Monta Rosa
09:00-10:30	Workshop 14 p. 69	Workshop 15 p. 70	Workshop 16 p. 71	Invited symposium p. 73	Research paper session p. 78-81	Paper session p. 82-85	Paper session p. 86-89	Workshop 17 p. 72
10:30-11:00 Coffee/Tea Break								
11:00-12:30	Workshop 18 p. 90	Workshop 19 p. 91	Invited symposium p.94-98	Invited workshop p. 99-103	Invited workshop 21 p. 93	Workshop 20 p. 92	Paper session p. 108-111	Paper session p. 104-107
12:30-13:45 Lunch break								
13:45-14:15 Plenary								
14:45-15:00 Short Break								
15:00-15:50 Plenary								
15:50-16:30 Panel discussion								
16:30	Closure							

Program overview

Pre conference workshops

Thursday April 17th

09.30 - 12.30 hrs. and 14.00 - 17.00 hrs.

Room

Differential diagnosis, treatment indication and (outcome) assessment of complex trauma related disorders (p. 1)

Chair: Nel Draijer, PhD

Presenters: Nel Draijer, PhD, Kathleen Thomaes, MD, Willie Langeland, PhD, and Suzette Boon, PhD

Matterhorn 1

The Use of EMDR and Guided Synthesis in the Treatment of Chronically Traumatized Patients (p. 2)

Chair: Anne Suokas-Cunliffe, MPhil, YM

Presenters: Anne Suokas-Cunliffe, MPhil, YM, Helga Matthess, MD, and Onno van der Hart, PhD

Matterhorn 2

After the diagnosis, What Next?

Phase I Treatment of Complex Dissociative Disorders (p. 3)

Chair: Kathy Steele, RN, MN, CS

Presenters: Kathy Steele, RN, MN, CS, and Suzette Boon PhD

Matterhorn 3

What's Really Going on With This Child? Understanding and Treating Traumatized Children with Dissociation (p. 4)

Chair & Presenter: Frances Waters, DCSW, LMFT

Zurich 1

The Role of the Body in the Treatment of Chronic Traumatization: A Psychology of Action (p. 5)

Chair & Presenter: Pat Ogden, PhD

Zurich 2

Thursday April 17th (evening)

18.00 – 21.00 hrs. **Registration**

19.30 – 21.40 hrs **Chair:** Suzette Boon, PhD
Matterhorn 1-2-3

19.30 – 19.40 hrs. **Welcome**
Suzette Boon, PhD, President ESTD, and Vedat Şar, MD, President ISST-D, on behalf of the International Society for the Study of Trauma and Dissociation (ISST-D)

19.40 – 19.45 hrs. **Conference opening**
Paul Lamers, Inspector of the Public Health
Supervisory Service, Health Care Inspectorate, The Netherlands

19.45 – 19.50 hrs. **"Old Scars, New Horizons: A Novel Way of Organizing Trauma Therapy and Research"**
Martijne Rensen, MA, Director, Netherlands Center for Early Childhood Traumatization (LCVT)

19.50 – 20.50 hrs. **Plenary - Pierre Janet Memorial Lecture:
120 Years of Dissociation: A History of Brilliant Insights, Lost Awareness and Stunning Disconnections** (p. 6)
Bessel van der Kolk, MD

20.50 – 21.40 hrs. **Plenary - Dissociation and the Dissociative Disorders in Europe: Theoretical, Scientific, and Clinical Advancements** (p. 7)
Ellert Nijenhuis, PhD

21.40 hrs Closure

Friday April 18th

9.00 -10.30 hrs. **Chair:** Nel Draijer, PhD

Matterhorn 1-2-3 **Plenary: From Infant Attachment Disorganization to Adult Dissociation** (p. 8)
Karlen Lyons Ruth, PhD
Discussant: Giovanni Liotti, MD, PhD

10.30 - 11.00 hrs. Break

11.00 - 12.30 hrs. **Concurrent sessions, symposia and workshops**

- | | |
|---------------------|--|
| <i>Matterhorn 1</i> | 1. Invited Workshop 1: EMDR with Chronically Traumatized Children and Adolescents (p. 11)
Renée Beer, MA; Carlijn de Roos, MA |
| <i>Winterthur</i> | 2. Workshop 2: Emergency Intervention in Art Therapy with EMDR and Somatic Experiencing (p. 12)
Judith Siano, MA |
| <i>Monta Rosa</i> | 3. Workshop 3: Ruling 'in' Dissociation and Attachment: A Mental Status Evaluation for All Ages (p. 13)
Anita Jones, PsyD |
| <i>Matterhorn 2</i> | 4. Workshop 4: Treating the “Impossible” Patient (p. 14)
Chair: Kathy Steele, RN, MN, CS
Discussant: Suzette Boon, PhD
Presenters: Suzette Boon, PhD; Nel Draijer, PhD; Richard Kluff, MD, PhD; Kathy Steele, RN, MN, CS; Catherine Fine, PhD |
| <i>Matterhorn 3</i> | 5. Invited Symposium: The Dutch Center For Chronic Childhood Traumatization (LCVT): A Source of Inspiration (p. 15)
Chair: Martijne Rensen, MA
Presenters: Martijne Rensen, MA; Tom Horemans, MD; Désirée Tijdink, MD; Willie Langeland, PhD
Organizing With Success: How to Achieve High-Quality Treatment in Specialized Trauma Centers – and Get Paid for it (p. 16)
Martijn Rensen, MA
The Use of Integrated Care Pathways in Implementing Diagnosis and Treatment of Childhood Trauma Survivors (p. 17)
Tom Horemans, MD; Désirée Tijdink, MD
Towards Better Insights and Outcomes: Developing and Implementing a Web-Based Information System (p.18)
Willie Langeland, PhD |

Zurich 1

6. **Paper Session: Attachment-Related Issues**
Chair: Annemiek van Dijke, MA
Reaching for Relationship: Exploring the Use of an Attachment Paradigm in the Assessment and Repair of the Dissociative Internal World (p. 19)
Sue Richardson, MA
Infanticidal Attachment: The Link Between DID and Crime (p. 20)
Adah Sachs, MA, APP, CAPP, UKCP
Trauma-related Adult Attachment Styles and Dissociation (p. 21)
Annemiek van Dijke, MA
Effects of Early Attachment Pattern on the Processes of Interpersonal Problem Solving and Explicit Memory (p. 22)
Yeşim Türköz, PhD

Zurich 2

7. **Paper Session: Case Presentations from Around the World**
Chair: Maire Riis, MA
A Case of Complex Posttraumatic Stress: Diagnosing and Treating Disorders of Extreme Stress (p. 23)
Laurie Brandt, PsyD
A Pioneering Case of DID from Iran: A Preliminary Report on Some Successful Techniques (p. 24)
Ali Firoozabadi, MD; Mohammad Jafar Bahredar, MSc; Parviz Bahadoran, MD
Using EMDR in Trauma Work with a Patient with a Dissociative Identity Disorder: A Dutch Example (p. 25)
Mariëtte Groenendijk, MA
Recovered Traumatic Memories through Eye Movements? A Case Presentation from Sweden (p. 26)
Luis Ramos-Ruggiero, Lic psychologist; Hans Peter Söndergaard, MD

St. Gallen

8. **Research Symposium Psychobiology**
Chair: Ellert Nijenhuis, PhD
Dissociation, Limbic Irritability, and Chaos in Autonomic Response in Patients with Unipolar Depression (p. 27)
Petr Bob, PhD; Marek Susta, PhD
Traumatic Stress, Dissociation, and Neuroendocrine Disturbances in Patients with Unipolar Depression (p. 28)
Marek Susta, PhD; Petr Bob, PhD
Associations between Childhood Trauma and Hypothalamic-Pituitary-Adrenocortical (HPA) Activity in Alcohol-dependent Patients (p. 29)
Ingo Schäfer, MD; Juliane Schulze; Lisa Teske; Katrin Homan; Johanna Hissbach, Dipl.-Psych.; Alexander Spauschus, MD; Christian Haasen, MD; Klaus Wiedemann, MD
The Dissociative Brain: Feature or ruled by Fantasy? (p. 30)
Simone Reinders, PhD; Marc van Ekeren, MSc; Herry Vos, MD; Jaap Haaksma, PhD; Antoon Willemsen, PhD; Hans den Boer, MD; Ellert Nijenhuis, PhD

12.30 - 13.45 hrs.

Lunch

13.45 - 15.15 hrs.

Concurrent sessions, symposia and workshops

Matterhorn 1

1. **Workshop 5: The Therapeutic Relationship: Counter Transference as Determining Factor in the Treatment of Seriously Traumatized Individuals** (p. 31)

Chair: Nelleke Nicolai, MD

Presenters: Nelleke Nicolai, MD; Jeanette de Waal, MA

Winterthur

2. **Workshop 6: The Fight to Survive - The World Through the Eyes of the Dissociative Infant and Toddler** (p. 32)

Renée Potgieter, PhD; Nancy Bolton, counselor

St. Gallen

3. **Workshop 7: Present Sexual Behavior/Sexual Functional Disorders of Survivors of Extreme Violence: An Integrated Treatment Approach** (p. 33)

Elke Kügler, Dipl.-Psych.

Zurich 2

4. **Workshop 8: The Impact of Institutional Dissociation on the Treatment Outcome of a DID Patient: A Single Case Study** (p. 34)

Remy Aquarone, MA

Matterhorn 2

5. **Workshop 9: Moods and Psychosis in Posttraumatic Disorders** (p. 35)

Andreas Laddis, MD

Matterhorn 3

6. **Symposium: Acute Psychiatry and Crisis Interventions** (p. 36)

Chair: Ursula Gast, MD

Axis-I Symptoms and Disorders in Patients with Complex Posttraumatic and Dissociative Disorders (p. 37)

Frauke Rodewald, PhD; Claudia Wilhelm-Göbbling, MD; Ursula Gast, MD

Trauma-focused Work at an Acute-Psychiatric Ward: Ward 54, Medical School Hanover (p. 38)

Svenja Bessling, Dipl.-Psych.; Frauke Rodewald, PhD; Claudia Wilhelm-Göbbling, MD

Energetic Psychotherapy in Stabilization-Groups for In- and Out-patients with Complex Posttraumatic and Dissociative Disorders (p. 39)

Claudia Wilhelm-Göbbling, MD; Frauke Rodewald, PhD

Time Effective Interventions: Techniques for Crisis Management in the Treatment of Dissociative Disorders (p. 40)

Peter Maves, PhD

Zurich 1

7. **Paper Session: Trauma and the Body**
Chair: Jim Helling, MSW, LCSW
Combat Trauma: Healing through Neural Education, Somatic Awareness, and Self Regulation (p. 41)
Mary Tendall, MA
Procedural Psychotherapeutic Treatment for Alexithymia and Somatoform Dissociation: A Case Study (p. 42)
Jim Helling, MSW, LCSW
Body Mentalization, Its Clinical Assessment and Therapeutic Application in the Treatment of Severe Unexplained Physical Symptoms (p. 43)
Jaap Spaans, MA; Martina Bühring, MD, PhD
Mentalization among Patients with Severe Psychosomatic Disorders (p. 44)
Lucie Veselka, MA; Martina Bühring, MD, PhD; Lonneke Prins, MA

Monta Rosa

8. **Paper Session: Clinical Approaches and Effectiveness**
Chair: Richard Klufft, MD
Dissociation and Interpersonal Relatedness (p. 45)
Russell Meares, MD
The Older Female Patient with a Complex Chronic Dissociative Disorder (p. 46)
Richard Klufft, MD
One Eye Integration (OEI): An Innovative & Flexible Therapy for Complex Trauma & Dissociation (p. 47)
Rick Bradshaw, PhD, RPsych.
Preliminary Results of a Naturalistic Study of Treatment Outcome for Patients with Dissociative Disorders (p. 48)
Bethany Brand, PhD; Catherine Classen, PhD; Ruth Lanius, MD; Richard Loewenstein, MD; Clair Pain, MD; Frank Putnam, MD; S. W. McNary

15.15 - 15.45 hrs. Break

15.45 - 17.15 hrs. **Concurrent sessions, symposia and workshops**

Matterhorn 1

1. **Workshop 10: The Use of the Screen Technique** (p. 49)
Michaela Huber, Dipl.-Psych.

Monta Rosa

2. **Workshop 11: The Clinical Assessment and Treatment of Trauma-related Self- and Affect-Dysregulation** (p. 50)
Annemiek van Dijke, MA

Matterhorn 2

3. **Workshop 12: The Joint Use of EMDR and Hypnosis in the Treatment of DID, DDNOS and Complex PTSD** (p. 51)
Catherine Fine, PhD

Matterhorn 3

4. **Workshop 13: Broken Bonds: A Sensorimotor Approach to Attachment, Trauma and the Body** (p. 52)
Pat Ogden, PhD

Zurich 1

5. **Invited Research Symposium: Disorders of Extreme Stress: Clinical Phenomenology, Effectiveness, and Neuroimaging** (p. 53)
Chair: Nel Draijer, PhD
Complex PTSD, Dissociative Disorders and Borderline Personality Disorder – Towards a Common Concept of Disorders of Extreme Stress (p. 54)
Martin Sack, MD; Bettina Overkamp, PhD; Birger Dulz, MD; Ulrich Sachsse, MD
Stabilizing Treatment Protocol for Phase I Treatment of Complex PTSD (p. 55)
Ethy Dorrepaal, MD; Kathleen Thomaes, MD; Nel Draijer, PhD
What are the Effects of a Stabilizing Group Treatment on Complex PTSD? Preliminary Data of a Multi Site RCT (p. 56)
Ethy Dorrepaal, MD; Kathleen Thomaes, MD; Jan Smit, PhD; Ton van Balkom, MD; PhD, Nel Draijer, PhD
Neurophysiological Correlates of Complex PTSD (p. 57)
Kathleen Thomaes, MD; Ethy Dorrepaal, MD; Nel Draijer, PhD; Michiel de Ruiter, PhD; Bernet Elzinga, PhD; Ton van Balkom, MD, PhD; Jan Smit, PhD; Dick Veltman, MD, PhD

Zurich 2

6. **Paper Session: Groups and Group Treatment**
Chair: Catherine Classen, PhD
Phase I Preparations of Severely Traumatized Women for Exposure by Extended EMDR-Protocols in Phase II Treatment (p. 58)
Anna Gerge, Leg. Psykoterapeut
A Mutual Aid Support Group for Persons with AIDS in Early Substance Abuse Recovery Who Have Experienced Early Childhood Trauma Impacting Affect Regulation, Sense of Self and Social Relations (p. 59)
Lawrence Shulman, MSW, EdD
The Impact of an Intensive Outpatient Program on Attachment Style Among Chronically Traumatized Women (p. 60)
Catherine Classen, PhD; Robert Muller, PhD

Winterthur

7. **Concurrent paper session: Clinical Interventions**
Chair: Paula de Jong, MA
One Solution Focused Way of Working with Dissociative Persons (p. 61)
Hélène Dellucci, Psychologist
Rebuilding the Self-structure: Using Time as a Neural Organiser (p. 62)
Nel Walker, psychologist / psychotherapist
Imagery Rescripting: Reprocessing Therapy in combination With a protocol for Psychomotor Therapy (p. 63)
Paula de Jong, MA; Marja Zwart, MA
Receptive Music Therapy: Guided imagery and Music (GIM), in Phase II Treatment for Women with Complex PTSD and DESNOS (p. 64)
Gabriella Rudstam, MA, Lic Psychotherapist

St. Gallen

8. **Paper session: From Experiential to Philosophical Approaches to Trauma**
Chair: Olaf Holm, MD
Therapist's Use of Oneself to Integrate the Many Selves of the Patient with DID (p. 65)
Rachel Gunner, MSW
The Adult Attachment Inventory (AAI) as a Therapeutic Intervention with a Patient with DDNOS: A Spanish Case Report (p. 66)
Olaf Holm, MD
Clinical Implications of "Integrative Theory of Dissociation" (p. 67)
Joan Lesley, MA
Traumatic Experience, Cartesian Dualism, and the Theory of Structural Dissociation of the Personality (p. 68)
Anssi Leikola, MD

17.30 - 18.30 hrs.
Matterhorn 2

Annual General Meeting of ESTD

19.30 - 21.30 hrs.

Optional: Candle-light dinner on boat through canals

Saturday April 19th

09.00 -10.30 hrs **Concurrent sessions, symposia and workshops**

- Matterhorn 1* 1. **Workshop 14: Effective Physical Enactments and Scenarios for Treating Dissociative Patients** (p. 69)
Ralf Vogt, PhD; Irina Vogt, Dipl.-Psych.
- Matterhorn 2* 2. **Workshop 15: Attachment-based Intervention Programs to Prevent Transgenerational Trauma** (p. 70)
Karl-Heinz Brisch, MD; A. Driessen, MD
- Matterhorn 3* 3. **Workshop 16: Anger Management and the Trauma Patient** (p. 71)
George F. Rhoades, Jr., PhD
- Monta Rosa* 4. **Workshop 17: What to do if the Mother of a Dissociative Child has Disorganized Attachment** (p. 72)
Sandra Wieland, PhD
- Zurich 1* 5. **Invited Symposium: Dissociation and Psychosis** (p. 73)
Chair : Andrew Moskowitz, PhD
Discussant: Mark van der Gaag, PhD
What is Dissociation and What is Psychosis? An Historical Examination (p. 74)
Andrew Moskowitz, PhD
Dissociation and Psychosis: An Examination of the Cognitive Experimental Literature (p. 75)
Martin Dorahy, PhD
Dissociation in Patients with Schizophrenia: Relationships with Childhood Trauma and Psychotic Symptoms (p. 76)
Ingo Schäfer, MD; Barbara Reitemeier; Liv Langer; Volkmar Aderhold, MD; Timo Harfst, PhD
The Relation between Psychotic and Dissociative Disorders: Comorbidity or Continuity? (p. 77)
Vedat Şar, MD
- Zurich 2* 6. **Research Paper Session: Prevalence**
Chair: Willie Langeland, PhD
Frequency of Dissociative Disorders Among Psychiatric Inpatients in an Iranian Clinic (p. 78)
Hossein Baghooli, MA; Ghasem Naziri, PhD; Cyrus Sarvghad, PhD
The Effect of Socio-Cultural Diversities on Dissociative Experiences (p. 79)
Mohsen Kianpoor, MD; Mohammad Bahredar, MA; Mohsen Yazdan-mehr, MD
Gender, Attachment Styles, Traumatic Events, Life Events, and PTSD in Faroese Eighth-Grade Students (p. 80)
Tora Petersen, PhD; Ask Elklit, MSc; J.G. Olesen
Lifetime Exposure to Traumatic Events and Post Traumatic Stress Symptoms in Iranian High School Students (p. 81)
Ahmad Ghanizadeh, MD; Maryam Tavassoli, MD

- Winterthur* 7. **Paper session: Treatment / Relationship Trauma**
 Chair: Remy Aquarone, MA
Involving People Who Lived Experience of Dissociative Disorders in Professional Training and Education (p. 82)
Kathryn Livingston; M. Goodwin
The Patient with a Learning Disability and Dissociative Identity Disorder (p. 83)
 Valerie Sinason, PhD
Creative and Concentration Meditation with DID Clients (p. 84)
 Christine Forner, BSW, RSW
Relationship Trauma: Grounded Theory Investigation of Women’s Traumatically Abusive Intimate Relationships (p. 85)
 Tricia Orzeck, PhD
- St. Gallen* 8. **Paper Session: Reactions to Trauma: Resilience and Re-offending**
 Chair: Vittoria Ardino, PhD
Personal Characteristics Affecting Psychological Stability of Battle-ried Military Personnel (Combatants) (p. 86)
Elena Isaeva, PhD; A. Degtyarev, MA; George Rhoades, PhD
Worrying about Trauma: Is This Linked to Re-Offending Risk? (p. 87)
Vittoria Ardino, PhD; Paola Di Blasio, PhD; Luca Milani, PhD
Posttraumatic Stress Regressive Syndrome (PSRS) in Russian Juvenile Prisoners (p. 88)
 Radik Masagutov, MD
Shame, Guilt and PTSD in a Sample of Childhood Sexual Abuse Victims (p. 89)
Alon Blum, MA; Ask Elklit, MSc.
- 10.30 - 11.00 hrs. Break
- 11.00 - 12.30 hrs. **Concurrent sessions, symposia and workshop**
- Matterhorn 1* 1. **Workshop 18: Borderline Psychosis, Double Binds and Chronic Relational Trauma in Borderline Personality Disorder** (p. 90)
 Ruth Blizard, PhD
- Matterhorn 2* 2. **Workshop 19: EMDR and EMDR Adaptations in The Treatment of Dissociative Disorders** (p. 91)
 Joanne Twombly, MSW
- Winterthur* 3. **Workshop 20 : Diagnosis and Treatment of Dissociative Disorders in a Transcultural Context** (p. 92)
 Marjolein van Duijl, MD
- Zurich 2* 4. **Invited Workshop 21: Shame and Dissociation: Utilizing Tompkins’ Innate Affect Theory and Nathanson’s Compass of Shame in the Treatment of DID and DDNOS** (p. 93)
 Richard Kluff, PhD, MD

Matterhorn 3

5. **Invited Symposium: Somatoform Dissociation** (p. 94)
Chair: Ellert Nijenhuis, PhD
Conceptual, Empirical and Classificatory Issues (p. 95)
Ellert Nijenhuis, PhD
Somatoform Dissociation and Traumatic Experiences in the General Population (p. 96)
Päivi Maaranen, MD; Antti Tanskanen, MD; Heimo Viinamäki, MD
Somatoform Dissociation in Medically Traumatized Children: A Norwegian Longitudinal Follow-up Study (p. 97)
Trond Diseth, MD
Somatoform Dissociation and Comorbidity in Turkish Clinical and Community Samples (p. 98)
Vedat Şar, MD

Zurich 1

6. **Invited Symposium: The Impact of Early Life Stresses on Attachment and Self-regulating Systems: Long-term Imprints?** (p. 99)
Chair: Eric Vermetten, MD, PhD; co-chair: Ruth Lanius, MD
Discussant: Bessel van der Kolk, MD
The impact of Traumatic Holocaust Experiences Across Three Generations: Attachment and Stress Regulation (p. 100)
Marinus van IJzendoorn, PhD; Mirjam Bakermans-Kranenburg, PhD
Child Maltreatment and Socio-Economic Risks in the Development of Disorganized Attachments (p. 101)
Mirjam Bakermans-Kranenburg, PhD; Marinus van IJzendoorn, PhD; C. Cyr; E. Euser
Attachment Representations in Dutch Military Veterans: Is Secure Attachment a Protective Factor in the Development of PTSD? (p. 102)
Dorith Harari, MD; Marinus van IJzendoorn, PhD; Mirjam Bakermans-Kranenburg, PhD; H.G.M. Westenberg, MD; Eric Vermetten, MD, PhD
Altered Self-Perception and Early Life Psychotrauma: A Compromised Default Network (p. 103)
Ruth Lanius, MD; R. Bluhm; P.C. Williamson; E. Osuch; T. Stevens

Monta Rosa

7. **Paper Session: Developmental Issues**
Chair : Karl Heinz Brisch, MD
An Inpatient Treatment Model for Severely Traumatized and Dissociative Children (p. 104)
Arianne Struik, MA; Sander van Arum, MD; Marcel Schmeets, MD
Trauma Scene Investigation (T.S.I.). Investigating and Structuring the Chaos in Families of Severely Traumatized and Dissociative Children (p. 105)
Anke van Schooten, MA; Arianne Struik, MA
Transgenerational Trauma: Diagnosis and Treatment of Attachment Disorders (p. 106)
Karl Heinz Brisch, MD

		<p>Nonverbal Behavior in Traumatized Patient: Comparison between Childhood Onset versus Acutely Adult Onset Trauma (p. 107) <u>Anne Kirsch, PhD</u>; R. Krause; S. Sachsse; J. Spang</p>
<i>St. Gallen</i>	8.	<p>Paper Session, Part 1: Secondary Traumatization Alternative to Violence Organizational Policy to Prevent and Reduce the Risk of Secondary Traumatization (p. 108) Judith van der Weele, MA</p> <p>When Trauma Therapists Dissociate: A New Approach to Secondary Traumatization (p. 109) Judith Daniels, PhD</p> <p>Paper Session, Part 2: Assessment Studies</p> <p>Diagnostic Drawing Series for Dissociative Adolescents: A Prospective Study (p. 110) Serge Goffinet, MD; N. Quevy, art therapist</p> <p>Validation of the Post-Traumatic Stress Disorder Checklist Scale (PCLS) in French and its Use in Cognitive-Behavioral Group Therapy (p. 111) <u>Valerie Ventureyra, PhD</u>; J. Cottraux, MD; S.Yao, MD; S. Kindynis, MA</p>
	12.30 - 13.45 hrs.	Lunch
	13.45 - 14.45 hrs	Chair: Eric Vermetten, MD, PhD
<i>Matterhorn 1-2-3</i>		<p>Plenary: Neurobiological Consequences of Childhood altreatment (p. 9) Martin Teicher, MD, PhD</p>
	14.45 – 15.00	Short break
	15.00 – 15.50 hrs.	Chair: Michaela Huber, Dipl.-Psych.
<i>Matterhorn 1-2-3</i>		<p>Plenary: Structural Dissociation of the Personality: The Key to Understanding Chronic Traumatization and Its Treatment (p. 10) Onno van der Hart, PhD</p>
	15.50 - 16.30 hrs.	Panel Discussion
	16.30 hrs.	<p>Closure Suzette Boon PhD</p>

Pre-conference workshops

DIFFERENTIAL DIAGNOSIS, TREATMENT INDICATION AND (OUTCOME) ASSESSMENT OF COMPLEX TRAUMA RELATED DISORDERS

Nel P.J. Draijer, PhD - Willie Langeland, PhD

Kathleen Thomaes, MD - Suzette A. Boon, PhD

No treatment without a proper diagnosis and an estimation of the prognostic possibilities of a patient. How to come about a well informed diagnosis in the complex trauma related continuum? Chronic trauma in childhood afflicted by the same people a child is dependent upon, results in complex trauma-related disorders such as complex PTSD and dissociative disorders, with or without personality pathology. These disorders may be accompanied by depression, eating disorders, sleep disorders, problems with affect regulation and self-destructiveness, self-esteem, relational problems, conversions, psychotic symptoms, etc. Most patients with complex trauma-related disorders have been treated for years before their symptom constellation is perceived within a trauma perspective and their possibilities to be treated differ widely.

So, what symptoms, in which constellation do we have to assess to be able to recognize them in a coherent trauma related perspective? What consequences has this diagnostic assessment for treatment? Treatment indication has to do with the level of functioning to estimate the possibility of treatment. This is more of a 'skill' and an art of weighing the gathered information. And – once in treatment – which symptom clusters are relevant to follow up during and after the intervention?

In the morning and early afternoon the major structured diagnostic interviews on dissociative disorders (SCID-D) and complex trauma (SIDES) will be presented, as well as the major screeners for dissociative pathology. New developments will be discussed.

For clinical purposes we will focus on core symptoms and their variety in clinical presentation and phenomenology - such as amnesia, for example - as well as on the level of functioning and of personal safety.

For research purposes in the afternoon outcome measurements will be addressed, focussing on the core symptoms of complex PTSD and dissociative disorders.



Educational objectives

1. Be able to diagnose Complex PTSD, Dissociative Identity Disorder (DID) and Dissociative Disorder Not Otherwise Specified (DDNOS)
2. Differentiate these diagnoses from (simple) PTSD, bipolar disorder, non-traumatized borderline pathology and malingered DID, a.o.
3. Describe the relevant characteristics to indicate treatment
4. List the core pathology of C-PTSD, DID and DDNOS and the major outcome measures

THE USE OF EMDR AND GUIDED SYNTHESIS IN THE TREATMENT OF CHRONICALLY TRAUMATIZED PATIENTS

Anne Suokas-Cunliffe, YM, Mphil

Helga Matthes, MD

Onno van der Hart, PhD



The treatment of traumatic memories in the therapy of chronically traumatized patients who have complex dissociative disorders needs careful preparation and the utmost care. The standard EMDR protocol is not sufficient for memory work with these patients, and can destabilize them. Thus, the therapist needs to have a good understanding of the dissociative personality structure that exists in these patients, including dissociative parts, their strengths and deficits, and their interrelationships. Using the framework of phase-oriented treatment and the theory of structural dissociation of the personality, this workshop will

help participants understand essential preparatory work which has to be completed before working through traumatic memories with EMDR, and become more knowledgeable about using modified EMDR approaches to work with traumatic memories in these complicated cases. The theory of structural dissociation helps the therapist become aware of which dissociative parts of the personality (and their interrelationships) need to be included in the preparation phase, which deficits need to be recognized and treated, and which resources need to be developed for the treatment of traumatic memories to be successful. Attention is also given to a comparative approach, i.e., guided synthesis. Both approaches need largely the same preparation. A modified protocol of EMDR for complex dissociation will be presented. Videos of EMDR and guided synthesis will be shown in the workshop.

Learning objectives:

1. Participants will be able to: Describe structural dissociation and why understanding of this phenomenon is needed for adequate treatment of traumatic memories
2. Apply specific modified EMDR protocols for the treatment of traumatic memories in complex dissociation
3. Describe the guided synthesis approach and how it differs from the EMDR approach

AFTER THE DIAGNOSIS, WHAT NEXT?

PHASE I TREATMENT OF COMPLEX DISSOCIATIVE DISORDERS

Kathy Steele M.N., C.S.

Suzette A. Boon, PhD.

Phase-oriented treatment, the accepted standard of care for complex posttraumatic stress and dissociative disorders (DDNOS and DID), stresses the need for careful pacing and regulation of arousal, because many patients have many debilitating symptoms, are especially prone to regulatory difficulties, and lack essential life skills. The first phase of therapy is thus focused on symptom reduction, stabilization, and skills building. Therapists often have many questions about this phase: How do I prioritize and begin treatment? How do I engage a patient who desperately demands help, but also views me with distrust and fear? How can I be in charge of the therapy while still making it a collaborative effort with the patient? How do I work with different kinds of dissociative parts, such as extremely dependent, avoidant, angry, or persecutory ones? How do I keep the focus of the whole person in a very complicated therapy in which I must work with parts? What are major pitfalls in Phase I? Two seasoned therapists will offer practical answers to these and other questions. We will discuss a step-wise treatment of common problems such as lack of healthy routine and structure in life (sleep, eating, balance between work, rest, and leisure), overwhelming feeling and flashbacks, impulsivity, and relational problems. Many of these difficulties and symptoms can be understood as stemming from a series of trauma-related phobias that maintain dissociation and hinder adaptive functioning in the present. We will begin with a very brief theoretical overview and move to essential treatment principles that organize therapeutic goals and interventions, regardless of the therapist's theoretical orientation. In the afternoon we will discuss a Phase I skills training manual for patients with a complex dissociative disorder (DID and DDNOS). Didactic presentations, case vignettes, and role play will be included.



WHAT'S REALLY GOING ON WITH THIS CHILD? UNDERSTANDING AND TREATING TRAUMATIZED CHILDREN WITH DISSOCIATION

Frances S. Waters, DCSW, Imft



Often times, traumatized children enter therapy with a plethora of behavioral and emotional symptoms, and with many plausible diagnoses. It is difficult to ascertain with such complex presentation and extensive symptomatology what may be operating within the abused child. Frequently children suffering from complex post traumatic stress disorder have experienced previous failed treatment and have had several diagnoses, which complicate the assessment and treatment process. They are unable to maintain themselves in their natural environment, cannot regulate their affect and behavior, and have a splintered sense of self. Children with dissociative features or with a dissociative disorder can present such a convoluted and disturbing picture. This workshop will describe the assessment process of traumatized children and adolescents for possible dissociative features and disorders. A multi-dimensional assessment approach will be outlined that includes extensive collateral contacts, careful analyses of past evaluations, previous treatment, and history of all forms of trauma. A thorough description of childhood dissociative indicators and differential diagnoses of maltreated children will be presented to enable the clinician to understand how traumatized, dissociative children can have varied comorbid symptoms, which may meet many diagnostic criteria. Child and adolescent dissociative and trauma checklists along with careful interviewing will be described to assist the clinician in appropriate diagnosis. An overview of The Quadri-Theoretical Model for Treatment of Dissociative Children (Waters, F. 1996) will be presented to lay the groundwork for a comprehensive approach to effective intervention. Specific techniques will be outlined which aim to assist the child in understanding his dissociative processes, to develop internal awareness, and cooperation among dissociative parts and learn effective stabilization techniques with the goal of gaining control over aggressive or self abusive behavioral problems and negative, destructive affect. Engaging the caregivers in the treatment process will be emphasized to resolve often severe attachment difficulties and provide specialized child management techniques geared toward stabilizing the dissociative child and maintaining placement. Careful processing of traumatic memories with the use of metaphors and symbols will be described. The use of clinical DVDs and artwork throughout the workshop will demonstrate the process of assessment and treatment of traumatized children with dissociation.

**The Role of the Body in the Treatment of Chronic Traumatization:
A Psychology of Action**
Pat Ogden, PhD.



Sensorimotor Psychotherapy is conducted within a phase-oriented treatment approach and this presentation will address interventions for all three phases of treatment: stabilization and symptom reduction, work with traumatic memory, and re-integration. Current research is showing major breakthroughs in what happens in the brain following trauma, indicating that insight and understanding may have only a limited influence on the operation of subcortical processes. A body-oriented approach is called for that facilitates new actions and addresses dissociative symptoms, including somatic components of traumatic memories (e.g., pain, analgesia, and motor inhibitions), and avoidance-related symptoms such as bodily anesthesia. Dr. Ogden will address the role of the body and of mindfulness in the treatment of chronic traumatization, using the theory and practice of Sensorimotor Psychotherapy, a clinical approach that integrates cognitive and somatic interventions in the treatment of trauma. Through videotaped excerpts of sessions with traumatized patients and brief experiential exercises, this workshop explores how people's minds and bodies process and interpret traumatic experiences, with a focus on how controlled action might help overcome traumatic repetitions and continued flight/fright/freeze/submit responses.

Learning objectives:

1. Recognition of trauma-related somatic symptoms
2. Describe body-oriented interventions for phase oriented treatment
3. Application of physical action in treatment for chronically traumatized and dissociative patients.

Key note lectures

120 YEARS OF DISSOCIATION: A HISTORY OF BRILLIANT INSIGHTS, LOST AWARENESS AND STUNNING DISCONNECTIONS

Bessel A. Van Der Kolk, MD (U.S.A.)



BIOGRAPHICAL NOTES

Bessel A. van der Kolk, MD has been active as a clinician, researcher and teacher in the area of posttraumatic stress and related phenomena since the 1970s. His work integrates developmental, biological, psychodynamic and interpersonal aspects of the impact of trauma and its treatment. His book *Psychological Trauma* was the first integrative text on the subject, painting the far ranging impact of trauma on the entire person and the range of therapeutic issues which need to be addressed for recovery. Dr. Van der Kolk and his various collaborators have published extensively on the impact of trauma on development, such as dissociative problems, borderline personality and self-mutilation, cognitive development in traumatized children and adults, and the psychobiology of trauma. He was co-principal investigator of the DSM IV Field Trials for Post Traumatic Stress Disorder. His current research is on how trauma affects memory processes and brain imaging studies of PTSD. Dr. Van der Kolk is past President of the International Society for Traumatic Stress Studies, Professor of Psychiatry at Boston University Medical School, Co-Director of the National Child Traumatic Stress Network Community Practice Site and Medical Director of the Trauma Center at HRI Hospital in Brookline, Massachusetts. He has taught at universities and hospitals across the United States and around the world, including Europe, Africa, Russia, Australia, Israel, and China. His latest book, co-edited with Alexander McFarlane and Lars Weisaeth, explores what we have learned in the past twenty years of the re-discovery of the role of trauma in psychiatric illness. *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society* was published by Guilford Press in May, 1996.

DISSOCIATION AND THE DISSOCIATIVE DISORDERS IN EUROPE: THEORETICAL, SCIENTIFIC, AND CLINICAL ADVANCEMENTS

Ellert R.S. Nijenhuis, PhD. (NL)



Dissociation and the dissociative disorders currently receive increasing interest in several European countries, although this progress tends to be local, dependent on the efforts of relatively few professionals, and opposed by antagonistic forces. In this presentation, the major theoretical, scientific and clinical advancements will be reviewed.

Theoretical work focuses on the concept of dissociation, ways in which the personality can become structurally dissociated, dissociative psychosis as a phenomenon and a diagnosis, the link between attachment disorders and major dissociative disorders, and the idea that conversion disorder is a dissociative disorder. Evolving research includes the psychology and psychobiology of dissociation and dissociative disorders, the epidemiology of dissociative disorders, and the relation between exposure to extremely stressful events and the emergence of dissociative symptoms and disorders.

Thus, one European longitudinal study clearly demonstrates a causal link between documented exposure to excessive stress in childhood and dissociative symptoms in early adulthood. Other research explored how patients with dissociative identity disorder (DID) have different psychobiological reactions to experimental challenges than healthy controls instructed to simulate DID.

New instruments are developed to evaluate the presence of dissociative symptoms and disorders. For instance, a new diagnostic interview is under construction that should help clinicians to distinguish more sharply between true and false positive cases of dissociative disorders than currently available tools allow. Clinically, Europe witnesses a major investment in the education and training of therapists in the state-of-the-art assessment and treatment of dissociative disorders and related disorders. This development is accompanied by an increase of mental health care institutions that provide treatment to patients with these disorders. Some ideas for further progress will be offered.

BIOGRAPHICAL NOTES

Ellert R.S. Nijenhuis, PhD., is a clinical psychologist, psychotherapist, and researcher. He engages in the diagnosis and treatment of severely traumatized patients at the Top Referent Trauma Center of Mental Health Care Drenthe, Assen, The Netherlands. He performs his scientific research at this hospital, and collaborates with universities in the Netherlands, Germany, and Switzerland.

FROM INFANT ATTACHMENT DISORGANIZATION TO ADULT DISSOCIATION

Karlen Lyons-Ruth, PhD. (U.S.A.)

While dissociation has been clearly related to severe and chronic abuse, many traumatic events do not result in serious symptomology. A model of fear regulation based on attachment theory would suggest that the impact of traumatic experiences is partially buffered by the quality of comfort and security available in primary attachment relationships or is exacerbated by relational processes that contribute to maintaining dissociation of mental contents. Dr. Lyons-Ruth will present recent findings from a 20-year longitudinal study on the contributions of the early parent-infant relationship and later trauma to dissociation in young adulthood. The implications of these developmental findings for clinical work with dissociative patients will be discussed.



BIOGRAPHICAL NOTES

Karlen Lyons-Ruth, PhD., is an Associate Professor of Psychiatry at Harvard Medical School, a member of the clinical staff and faculty at Cambridge Hospital, and principal investigator of the Family Pathways Project, an NIH-funded 20-year longitudinal study of predictors of adaptive social behavior from infancy to adolescence. Her research group is currently examining both genetic and caregiving influences on the developmental pathways leading to adolescent psychopathology, including dissociative and borderline symptoms. She is the author of numerous research articles and book chapters and speaks internationally on infant social development, maternal trauma and depression, and the parent-infant attachment relationship. Her clinical publications have proposed reorientations in psychoanalytic developmental theory based on the emerging body of developmental research findings. She is also a faculty member of the Massachusetts Institute of Psychoanalysis, an affiliate scholar of the Boston Psychoanalytic Institute, and maintains a private practice in Cambridge, MA.

FROM INFANT ATTACHMENT DISORGANIZATION TO ADULT DISSOCIATION: DISCUSSION OF KARLEN LYONS-RUTH'S PRESENTATION

Giovanni Liotti, MD, PhD (Italy)

In my discussion of Karlen Lyons-Ruth's presentation, I'll focus on three themes that are particularly interesting for clinicians.

The first one is a theoretical and research theme, concerning the controlling strategies and the hostile-helpless mental states, insofar as these strategies and mental states may clarify (1) the non overtly dissociative, but highly maladaptive features of their patients' attitudes in between the recurrences of overt dissociative symptoms, and (2) how these attitudes may be related to dissociation. It is very interesting for clinicians to understand that such untoward and seemingly opposite attitudes as hostility and compulsive caregiving may protect from (or defend against) the experience of "fright without solution" and the annihilating disassociation (disorganization - disorientation) of mental functions.

The second theme regards the conceptually extremely interesting even if statistically rather feeble relation between *early* attachment disorganization and later dissociative pathology. Disorganization of attachment may take place not only in infancy, but also in childhood or even in adolescence as the outcome of abusive or otherwise deeply confusing child-parent *attachment* interactions. If this is true, then the model of attachment disorganization in infancy as an early example of dissociation may apply also to later phases of development.

The model explains the *particular* importance of activating a cooperative system of dialogue rather than an attachment-caregiving system during the treatment of dissociative and borderline patients. This will constitute the third theme of my comments, hinting at the usefulness, in difficult cases, of parallel integrated treatments in counterbalancing with more cooperative attitudes the strong tendency toward the activation of the attachment system during the psychotherapy of these deeply suffering patients.

BIOGRAPHICAL NOTES

Giovanni Liotti, MD (1945)

Psychiatrist and psychotherapist practicing in Rome, Italy. Currently teaches "Implications of attachment theory for psychotherapy" in the APC School of Psychotherapy and in the Post-graduate School of Clinical Psychology of the Salesian University, Roma, Italy. His interest for the clinical applications of attachment theory and research dates back to 1975, and was first expressed in a book co-authored with V.F. Guidano, (*Cognitive processes and emotional disorders*, New York, The Guilford Press, 1983). Since then, this interest has focused mainly on the links between dissociative psychopathology and disorganization of attachment. For the papers published on this theme, he received the 2005 Pierre Janet's Writing Award (The International Society for the Study of Dissociation). He has been an invited speaker at the John Bowlby Memorial Conference, London 2007 and will be Keynote Speaker to the Royal Australian and New Zealand College of Psychiatrists Section of Psychotherapy Annual Bi-National Conference, 2008, on the theme of attachment disorganization in trauma-related disorders.

NEUROBIOLOGICAL CONSEQUENCES OF CHILDHOOD MALTREATMENT

Martin Teicher, MD, PhD. (U.S.A.)

Early severe stress and maltreatment produces a cascade of neurobiological events that have the potential to cause enduring changes in brain development. These changes occur on multiple levels, from neurohumoral to structural and functional. The major structural consequences of early stress include reduced size of the mid-portions of the corpus callosum and attenuated development of frontal, occipital and temporal cortex, hippocampus, and cerebellum.



These regions have different windows of vulnerability (sensitive periods) when they are most susceptible to the effects of early stress. The effects of early abuse on hippocampal volume may not manifest until late adolescents/early adulthood, and emergence of major depression may be delayed in many individuals until after puberty. Genetic polymorphisms appear to modulate risk or resilience to the effects of early abuse.

BIOGRAPHICAL NOTES

Martin H. Teicher, MD, PhD. has been Director of the Developmental Biopsychiatry Research Program at McLean Hospital since 1988. Dr. Teicher has served as an Associate Professor of Psychiatry at Harvard Medical School and Chief of the Developmental Psychopharmacology Laboratory at the Mailman Research Center since 1990. He is a member of the Editorial Board of the Journal of Child and Adolescent Psychopharmacology, Current Pediatric Reviews, and Current Psychosomatic Medicine. He is member of the Scientific Advisory Council of the Juvenile Bipolar Research Foundation, and been part of Harvard University's Brain Development Working Group. He has served on or chaired numerous review committees for the National Institute of Health, published more than 150 articles, and has received numerous honors.

STRUCTURAL DISSOCIATION OF THE PERSONALITY: THE KEY TO UNDERSTANDING CHRONIC TRAUMATIZATION AND ITS TREATMENT

Onno van der Hart, PhD. (NL)

Dissociation is an undue division of the personality, and is generally a highly misunderstood phenomenon, sometimes described in overly broad and confusing ways. Yet it plays a key role in the development and maintenance of a wide range of trauma-related symptoms and disorders, and thus it is crucial for clinicians to have a thorough understanding of this psychobiological phenomenon and its varied manifestations. Trauma-related dissociation involves a structural division among two or more psychobiological systems or “dissociative parts” that comprise the survivor’s personality. Each dissociative part involves relatively fixed psychobiological tendencies and its own sense of self, resulting in disruption of the normally cohesive and coherent functioning of the individual as a whole. Some dissociative parts are engaged in daily living and avoidance of traumatic memories, other parts are fixated in traumatic experiences and engaged in animal defensive actions. More severe and chronic traumatization may lead to more complex structural dissociation, and thus to more complex trauma-related disorders. Each treatment phase focuses on specific goals geared to the resolution of structural dissociation, i.e., to further personality integration and improved adaptive functioning. Treatment involves overcoming a series of trauma-related phobias. In this presentation attention is given to theory, research, and clinical practice.



BIOGRAPHICAL NOTES

Onno van der Hart, PhD, is honorary professor of psychopathology of chronic traumatization at the Department of Clinical and Health Psychology, Utrecht University, the Netherlands, and a psychologist/psychotherapist at the Sinai Center for Mental Health, Amsterdam, the Netherlands. Together with Ellert R. S. Nijenhuis and Kathy Steele he wrote *The haunted self: Structural dissociation and the treatment of chronic traumatization* (New York/London, 2006).

abstracts

EMDR with Chronically Traumatized Children and Adolescents

Renée Beer, MA; Carlijn de Roos, MA

In this workshop important aspects of the treatment, with EMDR as the main approach, of chronically traumatized children and adolescents will be discussed. What are the necessary conditions to be present or to be created in the preparatory phase of treatment? How much and what kind of stabilization is needed as the bottom line before trauma processing by EMDR can be initiated? An overview of empirical studies on treatment effects with this specific population will be discussed. Using video fragments, we will clarify how EMDR can be embedded in multifaceted treatment programs in different treatment settings. The question will be dealt with how parents can (not) be involved in order to reach optimal treatment outcome.

Learning objectives:

1. Enhance knowledge and understanding of the benefit of EMDR in the treatment of chronically traumatized children and adolescents
2. Enhance knowledge for identification of children and adolescents for whom EMDR may be appropriate.
3. Enhance understanding of the role for parents in the EMDR treatment with these clients

Emergency Intervention in Art Therapy with EMDR and Somatic Experiencing

Judith Siano, MA

The following presentation shows a model, which was built and applied with many different populations, children, aged people and adults, during the Lebanon War 2006 and after it. The purpose was prevention of PTSD and overcoming the difficult and painful period. Originally it was aimed at art therapists, psychologists, and other mental health staff – Jews and Arabs. They work with already traumatized children and youth in the shelled north of Israel, have to contain much pain and to be strong for others. They were close to break down, or already broke down. The same model served the presenter later in many cases of crisis, with groups and individuals. Especially it was adapted with some much dissociated clients, giving voice (visual representation) to the different sub – personalities. The model aims for (1) bridging between state of freezing or collapsing and functioning; (2) providing tools for self regulation and helping others to self regulate; and (3) strengthening the felt sense of well-being connected to resources within the person and preventing PTSD. The methods used are: (1) evaluation of body-sensation, feeling and thoughts with SUDS (Subjective Units of Disturbance Scale); (2) drawing a picture of resource; installation of resource; (3) drawing a deficiency picture, a picture which represents the disturbing part in one's present life; (4) EM (eye movements) between both pictures, through working in couples - bilateral stimulation; (5) re-evaluation of body – sensation, feeling and thought with SUDS.

Learning objectives:

1. To demonstrate the impact of art in developing inner boundaries towards integration of ego states.
2. To legitimize extreme emotions and to understand that they are normal defenses to trauma.
3. To acquire tools for coping with trauma in the present.

Ruling 'in' Dissociation and Attachment: A Mental Status Evaluation for All Age Anita Jones, PsyD

Clinicians in the field are the triage teams for further evaluation and treatment of children and adolescents. In addition to the standard interview questions, demographics, history and presenting problems, important clusters of behaviors and symptoms for which the clinician can probe are crucial for the purpose of evaluating dissociation and patterns of attachment. Unfortunately, since dissociative mechanisms are so often deemed to be extremely rare, mental health professionals are not prepared to assess their presence in patients. An argument for including queries for dissociative processes in all clinical evaluations will be made.

This paper will suggest a protocol for assessing dissociative phenomena in children and adolescents based on Loewenstein (1991) and Steinberg (1994) as well as my own experience.

Learning objectives:

1. Give reasons to include diagnostic queries for dissociative symptoms in children and adolescents.
2. Be able to approach the evaluation of children and adolescents with a protocol including ways to identify dissociative symptoms.
3. Know terminology useful in referring children and adolescents for additional evaluation and therapeutic intervention.

Treating the “Impossible” Patient

Chair: Kathy Steele, RN, MN, CS

Discussant: Suzette Boon, PhD

Presenters: Nel Draaijer, PhD; Richard Kluff, MD, PhD; Kathy Steele, RN, MN, CS; Catherine Fine PhD

Every therapist has encountered an “impossible patient” who engenders feelings of guilt, rage, shame, humiliation, helplessness, and incompetence, and who seems to resist virtually any efforts toward progress. In the face of massive resistance, the therapist may retreat into destructive enmeshment or distancing with the patient. The actual prognosis of an “impossible” patient depends to some degree on the goodness of fit between patient and therapist, and on the skills and experience of the therapist, as well as on certain prognostic indicators that should be used to screen for appropriateness for outpatient psychotherapy and to plan a workable therapy. The “impossible” patient can typically be understood as having extreme difficulties with four related issues: (1) dissociation; (2) chronic defenses against perceived relational threat (e.g., criticism, rejection, abandonment, or engulfment and control); (3) chronic defenses against inner experience (e.g., affects, cognitions, physical sensations, wishes, needs); and (4) difficulties in self regulation. Interventions are first directed to the *therapist*, who must learn to empathically understand the patient’s behavior, and act with reflection rather than with reaction. This reflective stance is a treatment strategy in itself for the patient, and paves the way for further interventions. Strategies for the therapist and patient will be discussed extensively. The presenters, who together represent well over a century of experience with “impossible” patients, will offer brief didactic components and case studies that highlight particular issues, including shame and narcissism, maladaptive dependency, severe attachment problems, and aggression.

Learning objectives:

1. Analyze resistances and formulate their protective value to the patient.
2. Demonstrate awareness of counter transference issues with difficult patients.
3. Discuss shame and its role in difficult patients.

The Dutch Center For Chronic Childhood Traumatization (LCVT): A Source of Inspiration

Chair: Martijne Rensen, MA

Presenters: Martijne Rensen, MA; Tom Horemans, MD; Désirée Tijdink, MD; Willie Langeland, PhD

Adult survivors of chronic traumatization in early childhood present with highly complex trauma-related disorders, such as complex PTSD or dissociative disorders, either with or without personality pathology. Although empirically supported treatments do exist for PTSD, chronically traumatized individuals are typically in need of more complex therapeutic interventions. The Dutch Center for Chronic Childhood Traumatization (LCVT) was recently established to address the lack of awareness at home and abroad about complex trauma-related disorders and the need for more treatment programs for survivors. The organization is dedicated to research, development, innovation, evaluation and education pertaining to specialized health care for this group. More specifically, it implements integrated pathways of care supported by guidelines for transparent, evidence-based diagnostics and treatment. Assessing and evaluating outcomes is a crucial element in treatment delivery.

Organizing with Success: How to achieve High-quality Treatment in Specialized Trauma Centers – and Get Paid for It

Martijne Rensen, MA

Dutch treatment providers have joined with patient organizations, policymakers and researchers to develop the LCVT model for integrated clinical pathways to treat disorders arising from childhood dramatization. The model has been implemented in Specialized Trauma Centers (TRTCs) throughout the Netherlands. The approach could be an inspiration to clinicians, researchers and patients elsewhere. The LCVT initiative is supported by patient groups, health insurance companies, the Netherlands Health Care Inspectorate and the professional trade organization for mental health and addiction services (GGZ Nederland). As one result of these concerted efforts, health insurers and GGZ Nederland have recently designated chronic childhood traumatization as a national focus for the Dutch mental health care system. Treatment in TRTCs is now covered by the Dutch standard health insurance package in a growth model. Five TRTCs were affiliated with the LCVT in 2007, and the number should rise to 10 in 2008. Besides improving the quality and reach of treatment services, the LCVT promotes greater effectiveness at lower cost by transforming lengthy inpatient careers into effective outpatient treatment pathways. All TRTCs are required to cooperate in building and sharing expertise, to take part in nationwide outcome research and to work according to uniform guidelines for diagnostics and treatment. To safeguard the specialized, tertiary status of the initiative, centers are admitted to the LCVT only after a stringent selection procedure.

The Use of Integrated Care Pathways in Implementing Diagnosis and Treatment of Childhood Trauma Survivors

Tom L.R. Horemans, MD; Désirée Tijdink, MD

Several leading Dutch mental health agencies took part in the LCVT initiative to improve treatment for survivors of chronic childhood trauma. Meetings were held with leading experts (several of whom were involved in creating the specialized Trauma Centers, TRTCs). The target population for treatment in the Centers was defined, and various patient subgroups (adults and children) were designated. The patient subgroups include patients with complex posttraumatic stress disorder (CPTSD); with personality problems (for children, emergent problems) with CPTSD or major dissociative symptoms; dissociative identity disorder; and with dissociative disorders not otherwise specified. These may or not exist in combination with one or more Axis I or Axis II diagnoses. Additionally, children may receive treatment for reactive attachment disorder or behavioral and/or adjustment disorders. Guidelines for state-of-the-art assessment and treatment were developed for selected pathways of care via a consensus procedure. The integrated care pathways approach was used to translate the LCVT principles into local practice in the different TRTCs. In this presentation, we describe and discuss the diagnostic and treatment pathways for the various patient subgroups.

Towards Better Insights and Outcomes: Developing and Implementing a Web-Based Information System

Willie Langeland, PhD

In recent public and political debates on mental health care, heavy emphasis has been put on 'delivering value for money', and an increasingly market-oriented health care funding system has given impetus to more transparency. As a consequence, the systematic evaluation of treatment outcomes is a crucial element in the LCVT model. A web-based information system has been developed to help collect and process data on the outcomes and effectiveness of treatment at centers for childhood traumatization. It should provide valuable data to patients, clinicians and researchers alike. This presentation discusses the standard outcome measures employed in the system.

Learning objectives:

1. To impart information and inspiration by describing the innovative LCVT approach to specialized health care
2. To trace the development of a multicentre outcome monitoring system
3. To describe how to make national- or regional-level data analyses in support of government or health-sector education campaigns.

Reaching for Relationship: Exploring the Use of an Attachment Paradigm in the Assessment and Repair of the Dissociative Internal World

Sue Richardson, MA

A new attachment paradigm (Heard & Lake, 1997; Heard, Lake, & McCluskey) is applied to work with dissociation. The paradigm identifies a dynamic process in which number of goal corrected systems take part, including care seeking and care giving, to restore a person's sense of well-being after it has been threatened. Inter-personal trauma disrupts this dynamic process and leads to a person's inter- and intra-personal relating being profoundly influenced by fear and the need for self-defense. The consequences of traumatic disruption of the dynamic process in those clients who have suffered extreme abuse is discussed. The dissociative inner world is understood as one in which a person is unable to reach inter- and intra-personal goals, in particular personal care giving. Patterns of intra-personal care seeking and care giving, the concept of an 'inner attachment interview' and the process of repair are examined. Clinical examples are given to show how the dissociative internal world can be restructured during attachment-based therapy. Attachment-based trajectories of repair are defined as a process of moving from an insecure to a more secure internalized environment via more effective intra-personal care seeking and care giving.

Learning objectives:

1. Learn about the application of an attachment paradigm to work with dissociation.
2. Identify attachment-based trajectories of repair.
3. Explore an attachment-based approach to internal restructuring.

Infanticidal Attachment: The Link between DID and Crime

Adah Sachs, MA, APP, CAPP, UKCP

This paper explores the connection between reported extreme abuse in childhood and DID, from an Attachment perspective. It uses a new Attachment classification by Kahr, Infanticidal Attachment (IA), to focus on the special role that serious crime (torture and murder) plays in the most severe forms of Dissociative Disorders. IA is defined as a sub-type of Disorganized Attachment, occurring in those infants whose Attachment-figure actively aims to torture, maim or kill them. These infants thus experience a reduction of stress when in the proximity of an infanticidal caregiver, and associate murderousness with safety. IA is placed at the bottom of the functionality scale of attachment types, as it decreases, rather than increases, the infant's physical and mental safety and chance of survival. The paper distinguishes between two states of mind in Infanticidal caregivers: the symbolic and the concrete, and subsequently identifies two Attachment styles, Symbolic IA and Concrete IA. Using clinical examples as illustrations, the paper postulates that while both types, depending on severity, could be devastating, only infants exposed to the concrete type of Infanticidal care giving are likely to develop DID. The diagnosis of DID may thus become an indicator for forensic concern.

Learning objectives:

1. To define IA as a sub-type of Disorganized Attachment
2. To distinguish between two states of mind in infanticidal caregivers, and subsequently two types of IA: the symbolic and the concrete.
3. To explore the connection between reported extreme abuse in childhood, DID and extreme crime from an IA perspective.

Trauma-related Adult Attachment Styles and Dissociation

Annemiek van Dijke, MA

Objective: Early interpersonal adverse experiences are considered contributors to the development of dissociation. Interpersonal trauma is associated with the development of insecure attachment. Attachment traumatized patients report difficulty trusting other people or maintaining relationships in the course of their lives. Little empirical literature is available that encompasses these specific components.

Method: In a sample 472 psychiatric patients BPD and somatoform disorder diagnosis was confirmed or ruled out using the Borderline Personality Disorder Severity Index, and the CIDI-section C. Reports of adverse experiences were collected using the Traumatic Experiences Checklist. Dissociation was measured using the Dissociative Experiences Scale and the Somatoform Dissociation Questionnaire-20. Adult attachment styles were assessed using the Relationship Styles Questionnaire.

Results: SoD patients reported more sub-clinical dissociative experiences and fewer psychoform (with or without somatoform) dissociative experiences than other groups. Contrarily, BPD+SoD patients reported fewer sub-clinical dissociative experiences and more psychoform (with or without somatoform) dissociative experiences. SoD patients proved significantly more likely to report secure adult attachment, and less likely to report insecure adult attachment than the BPD, BPD+SoD, or psychiatric control groups. Contrarily, BPD or BPD+SoD patients were significantly more likely to report fearful adult attachment style, and were less likely to report secure adult attachment style. Attachment trauma proved related to psychoform and somatoform dissociative experiences, fearful adult attachment style, fear of interpersonal closeness, and lack of interpersonal trust and negatively to model of other. Conclusions: This paper presents some preliminary results suggesting attachment trauma to be prominently related to psychoform dissociation and fearful adult attachment style.

Effects of Early Attachment Pattern on the Processes of Interpersonal Problem Solving and Explicit Memory

Yeşim Türköz, PhD

Objective: Attachment patterns which develop in the first year out of repeated patterns of the primary attachment relationship are believed to be maintained in the right orbitofrontal cortex, as implicit-procedural memory. They govern affect regulation, coping with stress and information processing. This study is designed to investigate whether attachment patterns have an effect on the stress coping mechanism and on the explicit memory processes, which begin to develop at the end of the first year.

Method: The sample of 77 5-6 years old preschool children from three different SES participated in this study. They were administered Attachment Story Completion Test, Children's Memory Scale, Problem Solving Story Completion Test and Interpersonal Problem Solving Teacher Observation Form. Statistical analyses were depended on the comparisons between secure and insecure groups on the measures.

Results: Significant differences were found between secure and insecure groups in terms of interpersonal problem solving behavior and memory performance. Secure children preferred assertive-positive coping behavior in face of the interpersonal stressful situations whereas insecure children usually turned to submissive or aggressive coping behavior. Findings also yield significant group differences in verbal memory tasks in favor of the securely attached group.

Conclusions: It was predicted that attachment patterns maintained in the implicit memory would affect the stress coping mechanisms and explicit memory systems through their closely related neuropsychobiological developmental trajectories. Outcomes of the study generally supported this prediction. Findings are discussed in relevance to the limitations of the study and suggestions for future research are presented.

A Case of Complex Posttraumatic Stress: Diagnosing and Treating Disorders of Extreme Stress

Laurie Brandt, PsyD

This presentation examines a case of complex posttraumatic stress with hallmark features of affect dysregulation, dissociation, disruptions in self-concept, vulnerability to repeated harm, somatization, and inability to experience meaning or purpose. It presents two diagnoses, utilizing existing DSM categories and the newly formulated DESNOS category. The treatment, based on the DESNOS diagnosis, utilized the tri-phasic model for the treatment of complex trauma. The study demonstrates that the current nosology is insufficient to describe the client's problems and to formulate effective treatment interventions. The DESNOS diagnosis addresses the problems of the DSM nosology by constellating the array of presenting symptoms into a single disorder. This cluster of symptoms reflects the findings of developmental psychopathology and neuroscience, which have identified significant developmental and neurobiological consequences of prolonged psychological trauma. Without an understanding of the traumatic origins of symptoms and the psychophysiological nature of complex posttraumatic stress, the primacy of treating self-regulatory deficits cannot be adequately understood. The DESNOS diagnosis offers an important step forward in the organization of our assessment and treatment of victims of prolonged interpersonal trauma. It is essential that this diagnosis be included in the clinical nosology to provide effective treatment and to avoid iatrogenic effects.

Learning objectives:

1. Compare and contrast a DSM diagnosis with a DESNOS diagnosis using a specific case study.
2. Demonstrate the advantages of the DESNOS model to both clinical formulation and treatment interventions.
3. Demonstrate the efficacy of the tri-phasic treatment model in cases of complex posttraumatic stress.

A Pioneering Case of DID from Iran: A Preliminary Report on Some Successful Techniques

Ali Firoozabadi, MD; Mohammad Jafar Bahredar, MSc; Parviz Bahadoran, MD

A documented case of DID has not been introduced yet in Iran. Mrs. Gandhi (one of alter names) was a 37-year-old single female who was referred to the first author by a colleague about 4 years ago due to a few suicidal attempts and a chronic depression. After a clinical interview, which included hypnosis, interviews with alters and video taping, and then presenting the patient in a case management conference, it turned out soon that she was a typical case of DID based on DSM-IV criteria. Psychotherapy included an insight-oriented approach as well as some innovative techniques namely, Combination (Merging 2 alter with similar personality traits in a unified alter by combination of her names Mina+Roya=Moya), Vacation (Temporary retreating an alter from the group during a crisis), and mirroring (Interviewing with alters, video taping and showing them to main personality). In the course of this therapy, the patient displayed a gradual and progressive change toward integration. In this paper, we review the abovementioned approach in detail and in relation to some cultural factors, such as the different effects and meanings of sexual trauma in eastern and western patients, in order to expand our knowledge about DID patients and their treatment.

Learning objectives:

1. To describe three techniques of combination, vacation and mirroring
2. To compare the different meanings of sexual trauma in Eastern and Western patients' minds
3. To compare repressive and dissociative strategies during the Oedipal phase.

Using EMDR in Trauma Work with a Patient with a Dissociative Identity Disorder: A Dutch Example

Mariëtte Groenendijk, MA

EMDR is a powerful technique for helping people overcoming their traumas. However, most of the clinical practice as well as the research have been focused on type 1 trauma and simple PTSD. Gradually the field is expanding to complex chronic traumatization and dissociative problems. In this case presentation I will share our first experiences in this challenging field. The case is about an older woman with DID who was treated in a residential psychotherapeutic setting. This is followed by a brief video-demonstration of EMDR with this DID-patient during a period of trauma work. After reporting on the process and outcome of this therapy, the conclusion will be that EMDR can be effective for dissociative patients suffering from early chronic severe and complex traumatization if several specific criteria are met. These criteria are about conceptualization according to the model of structural dissociation, about indication, timing, and preparation of the EMDR-sessions, about adaptation of the protocol, and about integration of EMDR in the broader phase-oriented state-of-the-art treatment of DID.

Learning objectives:

1. Witnessing the effect of EMDR.
2. Recognizing the clinical features of DID.
3. Encouraging therapists to indicate EMDR for complex trauma (under specific conditions).

Recovered Traumatic Memories through Eye Movements? A Case Presentation from Sweden

Luis Ramos-Ruggiero, Lic psychologist; Hans Peter Söndergaard, MD

This is a case presentation regarding the treatment of a severely traumatized woman formerly treated for depression and PTSD following incarceration in prison, “disappearance” of husband, and torture. After psychotherapy for several years, the patient improved and started to work in a qualified job. After some years, however, the patient returns because she has a feeling that the therapy was unfinished, and because of remaining psychosomatic symptoms, difficulties breathing, obesity, overeating, and recurrent urinary tract infections. The therapist then decided to try the resource installation protocol. However, in an impulse, he asked her to concentrate on her bodily sensations. Several video-recorded sequences illustrate how the patient, seemingly for the first time in her life, discovered and re-experienced childhood trauma. It seems that the eye movements during attempts at EMDR treatment made it possible to lift repression and dissociation as well as to make processing possible, thus liberating the patient from a heavy burden of mental and psychosomatic symptoms. At follow-up by the second author, the patient is entirely asymptomatic, with low DES scores and is no longer obese.

Learning objectives:

1. Somatoform symptoms as a bridge to dissociated traumatic childhood experiences
2. How dissociation might lift during treatment
3. Recent research findings regarding the effect of eye movements on episodic memory.

Dissociation, Limbic Irritability and Chaos in Autonomic Response in Patients with Unipolar Depression

Petr Bob, PhD; Marek Susta, PhD

Objective: According to recent findings stress experiences represent significant condition in pathophysiology of depression and influence abnormal development in the brain. Repeated stress and cognitive conflict also may determine dissociation, limbic irritability and temporal-limbic epileptic-like activity. Because recent findings indicate that epilepsy and epileptiform processes are related to increased neural chaos, in the distinct contrast to normal brain activity, the aim of this study is to find relationship between neural chaos in autonomic responses reflecting brain activity during stress activation and limbic irritability.

Method: For empirical examination of suggested hypothesis Stroop word-color test, ECG recording, calculation of chaos indices i.e. largest Lyapunov exponents (LLEs) in nonlinear data analysis and psychometric measures of limbic irritability (LSCL-33), dissociation (DES) and depression (BDI-II) in 40 patients with unipolar depression and 40 healthy controls were used.

Results: Significant correlation $r=0.69$ ($p<0.01$) between LLEs and LSCL-33 and correlation between LLEs and DES $r=0.70$ ($p<0.01$) found in this study indicate that degree of chaos in autonomic responses during conflicting Stroop task reflected by LLEs is closely related to limbic irritability. Significant correlation $r=0.48$ ($p<0.01$) also has been found between LLEs and symptoms of depression assessed by BDI-II. In the healthy control group similar correlations have not been found.

Conclusions: The results are in agreement with findings that epileptiform activity represents typical form of chaotic organization and indicate close relationship of chaos, dissociation and limbic irritability

Traumatic Stress, Dissociation and Neuroendocrine Disturbances in Patients with Unipolar Depression

Marek Susta, PhD; Petr Bob, PhD

Objective: According to recent findings stress represents significant condition in pathophysiology of depression and influence abnormal development in the brain. Repeated stress and cognitive conflict also may determine dissociation, limbic irritability and temporal-limbic epileptic-like activity. Because epileptiform processes are related to increased neural chaos a relationship between chaos, limbic irritability and dissociation as a consequence of traumatic stress was previously proposed (Bob, 2003 Int J Neurosci, Bob et al., 2006 Phys Res, 2007 Int J Clin Exp Hypn).

Methods: For empirical examination Stroop word-color test, ECG recording, calculation of chaos indices i.e. largest Lyapunov exponents (LLEs) in nonlinear data analysis and psychometric measures of limbic irritability (LSCL-33), dissociation (DES) and depression (BDI-II) in 40 patients with unipolar depression and 40 healthy controls were used.

Results: In the group of depressive patients significant correlation $r=0.69$ ($p<0.01$) between LLEs and LSCL-33 and correlation between LLEs and DES $r=0.70$ ($p<0.01$) found in this study indicate that degree of chaos in autonomic responses during conflicting Stroop task reflected by LLEs is closely related to limbic irritability. Significant correlation $r=0.48$ ($p<0.01$) also has been found between LLEs and symptoms of depression assessed by BDI-II. In the healthy control group significant correlations between LLEs and results of psychometric measures were not found.

Conclusions: The results are in agreement with findings that epileptiform activity represents typical form of chaotic organization and indicate close relationship of chaos, limbic irritability and dissociation.

Associations between Childhood Trauma and Hypothalamic-Pituitary-Adrenocortical (HPA) Activity in Alcohol-Dependent Patients

Ingo Schäfer, MD; Juliane Schulze; Lisa Teske; Katrin Homan; Johanna Hissbach, Dipl.-Psychol.; Alexander Spauschus, MD; Christian Haasen, MD; Klaus Wiedemann, MD

Objective: The consequences of Childhood trauma (CT) become increasingly apparent. The available data suggest that (1) CT is related to persisting alterations of HPA activity, (2) CT is related to psychopathology in patients with substance use disorders (SUD), and (3) alterations of HPA activity are related to craving and psychopathology. However, none of the existing studies have tried to integrate these different perspectives.

Methods: We assessed anxiety (STAI), depression (BDI) and craving (OCDS-D) in a consecutive sample of 42 patients with alcohol dependence (37% female, 63% male) on day 1 (t1) and day 14 (t2) after their admission to a detoxification unit. Morning plasma levels of cortisol and ACTH were assessed and a standard dexamethasone test (DST) was performed (t2). Finally, the Childhood Trauma Questionnaire was administered.

Results: At t1, cortisol levels correlated significantly with anxiety ($r=.34^*$) and sexual abuse ($r=.38^*$). An inverse relationship was found between ACTH levels and both, emotional abuse and emotional neglect (t1: $r=-.33^*$, $r=-.39^*$; t2: $r=-.32^*$, $r=-.51^{**}$). This relationship persisted when controlling for depression. Craving was related to anxiety and depression (t1: $r=.53^{**}$, $r=.60^{**}$; t2: $r=.39^*$, $r=.35^*$), but not to cortisol or ACTH levels. No relationships existed between CT and the DST outcome.

Conclusions: Our results give first evidence that CT is related to changes of the HPA activity in SUD patients, but they could not be further clarified by the DST.

Psychopathology was related to both, early trauma and craving. Future studies should try to further examine these complex relationships.

The Dissociative Brain: Feature or Ruled by Fantasy?

Simone Reinders, PhD; Marc van Ekeren MSc; Herry Vos, MD; Jaap Haaksma, PhD; Antoon Willemssen, PhD; Hans den Boer, MD; Ellert Nijenhuis, PhD

Objectives: Despite the recognition of dissociative identity disorder (DID) in the DSM IV, there is no general agreement about the origin and biological foundations. The traumagenic view states that DID constitutes a severe form of post-traumatic stress disorder while the iatrogenic view asserts that DID originates from suggestion or role-playing, being facilitated by a high level of fantasy proneness.

Research question: Can healthy controls simulate DID?

Methods: The current study compares autobiographical memory processing (i.e. inter-identity amnesia) in 11 DID patients (Reinders e.a. 2006) to both 9 high (14.11 +/- 5.15) fantasy prone (FP: measured with the CEQ (Merckelbach e.a. 2001) and 9 low (4.6 +/- 2.51) FP control subjects. A symptom provocation paradigm was applied in a three-by-two-by-two factorial design setting. Both a (simulated) 'neutral identity state' and a (simulated) 'traumatic identity state' were exposed to a neutral and a trauma-related memory script. Three psychobiological parameters were tested: subjective ratings, cardiovascular responses, and regional cerebral blood flow (rCBF) as measured with positron emission tomography.

Results: So far, our results indicate that inter-identity amnesia, with respect to emotional autobiographical memories, is a specific feature of DID patients. Furthermore, fantasy proneness does not seem to facilitate the ability to (fully) simulate emotional responses.

Conclusions: Directly compared with patients, high nor low FP DID simulating controls are able to (fully) mimic dissociative identity states that are observed in DID patients. More specifically, our results do not support an iatrogenic origin of DID.

The Therapeutic Relationship: Counter Transference as Determining Factor in the Treatment of Seriously Traumatized Individuals

Chair: Nelleke Nicolaï, MD

Presenters: Nelleke Nicolaï, MD; Jeanette de Waal, MA

As decades of research have repeatedly shown, a major factor determining positive psychotherapy outcome is formed by the quality of the relationship between psychotherapist and patient. However, because of the intensity and unpredictability of the emotional reactions of seriously traumatized patients or patients diagnosed with DID, their treatment poses a very specific challenge to therapists. We can draw a comparison between the function of parents as external stress-regulators for their infants and the role of the therapist in relation to his/her patients. The ability of the primary caregivers to tolerate and contain the emotions of the infant will determine their capacity to reduce the physical stress reactions of their child through the use of different nonverbal soothing techniques. This in turn will protect the infant from the effects of overwhelming affect and emotional deregulation. Parents who are unable to contain their own stress reactions will themselves become part of an unpredictable and insecure environment, leading to chaotic internal attachment representations. This in turn leads to an impaired capacity for the regulation of the autonomic nervous system stress reactions and to disturbed relationships in later life. In the therapeutic relationship, the function of external affect regulator falls to the therapist. However, this relationship activates the early attachment experiences and inner working models of both therapist and patient. The capacity of the therapist to tolerate, contain and explore the emotions of the patient while at the same time remaining in contact with his own emotional inner world, will determine both the content and the intensity of what can be explored, and will therefore set the boundaries for what can be achieved in therapy. The ability of the therapist to become aware of his/her own bodily reactions is crucial. These bodily reactions not only mirror the inner turmoil of the patient but also reactivate the unconscious attachment system of the therapist. Using actors trained in playing the role of patient, and together with the workshop participants, we will demonstrate the importance of non-verbal, bodily reactions on the part of the therapist.

Learning objectives:

1. To help therapists to become aware of these bodily reactions and the emotions underlying them, with the aim of increasing the ability of the therapist to tolerate and contain these emotions;
2. To help therapists become conscious of the way in which these reactions implicitly, on a non-conscious level, influence our psychotherapeutic interventions.
3. To explore and make explicit the ways in which these insights can be used in the treatment of seriously traumatized patients.

The Fight to Survive - The World Through the Eyes of the Dissociative Infant and Toddler

Renée Potgieter, PhD, Nancy Bolton, counselor

In the therapy field there is a dispute whether infants and pre-verbal children can dissociate.

The presenters work in the field of adoption where children in adoptive placements are presenting with a range of difficult behaviors. Many of these children and their adoptive parents are struggling due to the children's dissociation resulting from complex trauma that they have suffered while living with their birth families. Some of the children report the onset of the dissociative parts at a pre-verbal phase. This onset coincides with the development of a disorganized attachment to the parents and the experience of complex trauma. It is compounded by multiple moves to different carers. During this workshop theory underpinning the experiences of dissociation of the infant and pre verbal child will be evaluated. This will be done by looking at the theories of Melanie Klein and of Daniel Stern about the development of the self of the infant. The process of dissociation as a result of complex trauma in a disorganized attachment will be discussed. It will be illustrated by clinical case material, drawings of the children and video clips of therapy sessions.

This will also include specific focus on the pre-natal experiences of one child recalling intra uterine trauma and resulting dissociation. The presentation will also include a model of working with these children successfully through addressing their attachments as well as processing the complex trauma and dissociation.

Learning objectives:

1. To discuss the theory around the development of dissociation in infants and toddlers.
2. To evaluate the subjective experiences of children who started to dissociate as infants and toddlers due to complex trauma in disorganized attachments.
3. To discuss the case of a child recalling pre-birth trauma and her journey through dissociation to healing.

Present sexual behavior/sexual functional disorders of survivors of extreme violence – Treatment under aspects of Structural Dissociation Therapy, Cognitive Behavior Therapy and Sexual Therapy

Elke Kügler, Dipl.-Psych.

Present sexual behavior and functional problems of chronically traumatized patients with DID, DDNOS or DESNOS are often neglected in trauma therapy. Extreme violence and dissociative symptoms are often neglected in sexual therapy and (cognitive) behavior therapy. Structural dissociation is neglected both in behavior therapy and in sex therapy. Patients with sex problems such as functional disorders usually hardly find adequate help, even though suffering from various psychiatric symptoms connected. Therapists are often not very well trained in sex-therapeutic interventions.

This workshop will focus on sex therapy along the integrative Hamburger Modell based on learning theory. Compared to „normal sexuality“, dissociating individuals show specific manifestations, e. g. switches or depersonalization symptoms during coitus, which will be dealt with. Sex therapy of functional disorders will be surveyed. A diagnostic interview will be demonstrated by roleplay and elements of therapy are introduced as well as literature and hints for further training. The participants' difficulties concerning the sexuality topic will be dealt with. Participants should have good knowledge of structural dissociation.

Learning objectives:

- 1 Realize that your traumatized patient has an everyday's sex life besides trauma, with some specific manifestations,
- 2 Sexual dysfunctions: Introduction to definitions, diagnoses and therapy,
- 3 Basics/encouragement to treatment processes of sexual problems of DID, DDNOS or DESNOS patients.

**The Impact of institutional dissociation on the treatment outcome of a DID patient:
A single case study**
Remy Aquarone, MA

The treatment of patients with complex trauma cannot be undertaken in isolation. Unlike traditional psycho-analytic work, where the exclusive focus of the work is on the inner world of the patient within the watertight bubble of the consulting room, DID patients involved with other mental health professionals will require a unified and inter-relational approach. Without a sustainable holding environment from all professionals involved in the care of such patients, no positive prognosis is possible for the person being treated.

The case presented will demonstrate the initial splitting between the professionals involved, the projections from the patient of her dissociated selves and the counter-transference reactions from this multi-disciplinary staff.

Eventual improved communication between the professionals (the institutional equivalent of good internal communication between the part with the patient present) led to a safe contained environment so that work in individual sessions could be sustained.

Learning objectives:

1. Describe the impact of the patient's childhood history on the reactions of the professionals involved.
2. Demonstrate the change in the patient's hyper and hypo arousal once a contained environment was established.
3. Identify the implications for therapists whether working privately or within a mental health team.

Moods and Psychosis in Posttraumatic Disorders

Andreas Laddis, MD

For more than a decade, American clinicians have followed a fad of misdiagnosing complex posttraumatic disorders as bipolar disorder for their mood swings and racing thoughts, or as schizophrenia for their hallucinations and delusions. It is seductive to do so because these four symptoms are as pervasive and disabling in posttraumatic disorders as in bipolar disorder or in schizophrenia. Testing for dissociative symptoms alone easily distinguishes posttraumatic disorders from other mental disorders. But we can discredit this fad more effectively by challenging it head on, for its crudeness of equating all kinds of irrational mood changes with bipolar disorder and all kinds of psychosis with schizophrenia. On closer look, the mood swings and racing thoughts in posttraumatic disorders are strikingly different in their course and content from those in bipolar disorder. The same applies to hallucinations and delusions of posttraumatic disorders and schizophrenia. Moreover, all four symptoms are patently similar among all variants of posttraumatic disorder, e.g., Dissociative Identity Disorder, Complex Posttraumatic Stress Disorder and Borderline Personality Disorder. Three recent studies by Laddis and Dell will be reviewed. They compare DID with Borderline PD, Bipolar Disorder and Schizophrenia. Also, a comprehensive description of the four symptoms will be presented to demonstrate their unique character in posttraumatic disorders.

Learning objectives:

1. Explain the pitfalls of diagnosing different symptoms as comorbid disorders too easily
2. Describe the typical hallucinations of posttraumatic disorders.
3. Describe the unique characteristics of racing thoughts in posttraumatic disorders.

Notes

Axis-I Symptoms and Disorders in Patients with Complex Posttraumatic and Dissociative Disorders

Frauke Rodewald, PhD; Claudia Wilhelm-Gößling, MD; Ursula Gast, MD

Objective: Patients with complex posttraumatic and dissociative disorders often suffer from many psychopathological symptoms and disorders. However, only a few researchers have investigated the number and type of comorbid disorders in this population by diagnostic interviews.

Method: Data from 44 patients with DID, 22 with DDNOS and 13 with complex PTSD for number and type of axis-I-disorders will be compared with those of 17 patients with depression, 14 with anxiety disorders and 30 non-clinical controls.

All participants were administered the diagnostic interview for psychiatric disorders (short version; Mini-DPS), as part of a thorough study on diagnosis of complex dissociative disorders. Data were collected at Medical School Hanover and at the Clinic for Psychotherapeutic and Psychosomatic Medicine Bielefeld.

Results: Only one non-clinical participant met diagnostic criteria for an axis-I disorder. Most patients with depression or anxiety disorders received the diagnosis of 1 – 3 disorders and the average number of psychiatric disorders diagnosed in patients with PTSD, DDNOS and DID ranged from 3,5 to 4,9.

Most prevalent disorders in patients with PTSD, DDNOS and DID were PTSD, anxiety disorders, depression and somatoform disorders. A striking resemblance of the Mini-DIPS-profiles was found in these three groups, while the profiles of the other groups differed significantly.

Conclusion: These findings confirm the hypothesis, that PTSD and complex dissociative disorders are syndromes with many comorbid disorders and they confirm the recent tendency, to conceptualize PTSD and major dissociative disorders as etiological and phenomenological related disorders.

Trauma-focused Work at an Acute-Psychiatric Ward: Ward 54, Medical School Hanover

Svenja Bessling, Dipl.-Psychol.; Frauke Rodewald, PhD; Claudia Wilhelm-Gößling, MD

Many people believe that conducting trauma-focused work in acute psychiatric clinics is almost impossible. Yet, our clinical experience contradicts this opinion. Ward 54 is an acute general psychiatric inpatient ward. Traumatized patients often enter the clinic after suicide attempts, due to uncontrollable self-injury, dissociative or posttraumatic symptoms etc. Treatment options cover e.g. trauma-focused differential-diagnoses, individual treatment, socio- and psychotherapeutic crisis intervention and trauma-specific stabilization groups. Based on a case example, clinical inpatient work with traumatized patients is presented. The patient, an 18-year old woman, entered the clinic after a suicide attempt. By then, she was living with her parents, being exposed to physical and sexual abuse and suffering from a range of psychopathological symptoms and social problems. During inpatient treatment, she was diagnosed as DID. After inpatient treatment, she was able to leave home and moved to an assisting living facility for traumatized girls. She was able to return to school and her symptoms and social skills improved. Yet, 6 month later, she reentered the clinic due to an acute crisis. She was then introduced to more symptom-management techniques and attended a trauma-focused stabilization group. In the one on one setting, specific stressors, which had lead to decompensation were processed, using energetic psychotherapy. After the second stay, she returned to outpatient psychotherapy and is continuing to improve. The case example demonstrates how acute psychiatric inpatients may benefit from trauma-focused treatment and it illustrates how these kinds of interventions can be integrated in the everyday work of an acute psychiatric ward.

Learning objectives

1. Outline different treatment options of trauma-focused work under acute psychiatric conditions.
2. Understand the impact of implementing trauma-focused work in acute psychiatric clinics.
3. Learn about a case example of a traumatized patient with DID- diagnosis and the effective intervention in an acute clinical setting.

Energetic Psychotherapy in Stabilization-Groups for In- and Outpatients with Complex Posttraumatic and Dissociative Disorders

Claudia Wilhelm-Gößling, MD; Frauke Rodewald, PhD

Patients with a history of complex traumatization and posttraumatic disorders like complex PTSD, DID or DDNOS are often challenging therapists and treatment-teams, as they often suffer from a wide range of symptoms and having a greater risk for decompensation, which may lead to acute suicidality, self-injury, depression, severe dissociative or posttraumatic symptoms etc. In order to help patients mastering such problems, the psychiatric clinic of Medical School Hanover offers trauma-focused in- and outpatient stabilization-groups to patients with complex posttraumatic disorders. The sessions are divided into two parts: 1. Psychoeducation on psychobiology of trauma, posttraumatic and comorbid symptoms, symptom-management, treatment strategies etc., and 2. Training of stabilization techniques, like resource-activation, imagination-techniques, and symptom-management strategies. One of the strategies, being taught, are specific techniques using energetic psychotherapy (EP), a treatment-technique, which is based on the assumptions of traditional Chinese medicine. By tapping specific acupuncture-points, energetic barriers shall be relieved, which may help to decrease stressing emotions and symptoms or in a modern neurobiological way, EP can be seen as a brief multisensory and bilateral activation, which helps to fasten integration of traumatic experience. In this presentation, concepts for the in- and out-patient stabilization groups are presented, emphasizing on opportunities, as well as limitations in the use of EP with this population. Clinical experience and participants' feedback demonstrate that EP is an easy manageable and effective self-help technique for posttraumatic symptoms. Additionally, patients, having problems with relaxation techniques or imagination may benefit to a great extent from the active technique of tapping.

Learning objectives:

1. Outline frequent symptoms and comorbidity of complex PTSD, DDNOS and DID and possible group-interventions how to deal with them.
2. Learn about some basics of Energetic Psychotherapy (EP) and how to tap the acupuncture-points within two treatment-protocols.
3. Assess limitations of EP especially in DID and gather information about some practicable modifications of the technique.

Time Effective Interventions: Techniques for Crisis Management in the Treatment of Dissociative Disorders

Peter Maves, PhD

In the treatment of dissociative disorders, a consistent and persistent task is the management of patient crisis points. These situations can range from true and actual emergencies, to para-suicidal gestures and “emergency feelings” associated with patients’ daily life experiences. The treatment process can feel like a chronic series of crisis presentations and “tests” that many times appear to overshadow and sidetrack longer-term treatment goals. This presentation will present a variety of time effective and focused treatment interventions, which not only can aid in the resolution of the crises, but also utilize these crisis presentations to further ongoing treatment. Intervention examples will include De Shazer’s (1985) “Problem Solving” techniques, Dowd and Milne’s (1986) paradoxical interventions and a range of affect modulation approaches (Steele, 1989) combined with “third-generation” cognitive techniques. Case examples will be presented and audience case questions about difficult crisis situations will be encouraged.

Learning objectives:

1. Understand the range and quality of patient emergency and crisis presentations associated with dissociative disorders.
2. Learn the basic tenets of time effective, focused treatment interventions and their application to the crisis needs of dissociative patients.
3. Gain an understanding of which time effective interventions to utilize under specific conditions, through case presentations and questions.

Combat Trauma: Healing through Neural Education, Somatic Awareness, and Self Regulation

Mary Tendall, MA

Posttraumatic stress disorder and dissociation have increased in population as a result of current global war zones. Combat trauma has impacted not only soldiers and veterans, but also their families. Our globalized citizens have lost many of the cultural traditions which once offered significant elements of safety and healing, therefore, therapeutic measures must be counted on to reduce and eliminate trauma symptoms. Although combat veterans return home expecting life to return to normal, the sustained vigilance inherent in a combat zone and the specific experiences of conflict create a neural pathway of combat readiness which retains vigilance after the soldier's return, and sustains itself without effective intervention. A soldier is trained to kill, and the duality he or she is caught in upon returning to a safe environment causes a mask of normalcy to be worn while at the same time there is an inner feeling of fear and dread. By teaching and objectifying the combat related neural response to sustained trauma exposure, the patient gains an understanding and acceptance of his condition. Clinical intervention along with teaching the patient to use self-regulating techniques have successfully decreased and eliminated the trauma response in the combat veteran's brain. When the soldier utilizes self-regulating tools, he is capable of taking an active role in the healing process. This is especially important for a combat veteran.

Learning objectives:

1. Offer information showing how the neural pathways respond to sensory input following a traumatic experience
2. Show how triggered reactivity in the brain stem manifests itself in the physical body.
3. Give examples of self-regulation tools that a patient can use to calm the nervous system and reprogram the brain stem's reactivity.

Procedural Psychotherapeutic Treatment for Alexithymia and Somatoform Dissociation: A Case Study

Jim Helling, MSW, LCSW

Somatoform dissociation, defined as disruption of hierarchical representation of embodied experience, is an important clinical feature of posttraumatic alterations in mental function. Somatoform disruptions of reflective functions commonly manifest in alexithymic presentations. Traditional psychotherapeutic approaches relying on declarative operations are poorly suited to be mutative in such cases, where the primary deficit involves discoordination of multiple levels of information processing including procedural operations. Exposure to extreme stress functionally disconnects declarative and non-declarative representational systems and fragments representational operations within procedural processing circuits, compromising executive, cognitive, narrative, and self-regulatory activities. Deficits in procedural processing of affect, termed apraxithymia, underlie the manifest impoverishment of declarative function in these cases. Intervention strategies that target non-declarative representational systems facilitate reintegration of embodied, procedural operations and create the foundations for development of higher levels of emotional awareness and coherent narrativization. Theory and practice of procedural psychotherapy is explored through the case of a young adult patient with an extensive childhood trauma history and complex dissociative symptomatology including alexithymia. Sensorimotor Psychotherapy is presented as an example of a procedural approach to early-stage trauma treatment that has shown promise in building relational, information processing, and self-regulatory capacity.

Learning objectives:

1. To differentiate operations of procedural and declarative information processing systems in the context of alexithymic presentations.
2. To reformulate posttraumatic alexithymia as a non-declarative disruption of hierarchical information processing functions.
3. To describe procedural psychotherapeutic strategies that target non-declarative systems for treatment of posttraumatic alexithymia.

Body Mentalization, Its Clinical Assessment and Therapeutic Application in the Treatment of Severe Unexplained Physical Symptoms

Jaap A. Spaans, MA; Martina E.F. Bühring, MD, PhD

Body mentalization can be defined as the ability to perceive one's own body signals and those of others, be receptive to them, and experience their connection to the underlying mental states. This ability is often suppressed in patients with physically unexplained symptoms and a history of severe (bodily) traumas and insecure attachment. A body mentalization-based therapy for somatoform disorders focuses explicitly on the mentalization of body signals. Therapists try to recognize the manifestations of the inability of body mentalization and help patients give mental meaning to the perception of their own body signals as well as those of others. They work with explicit exercises, methods and typical therapeutic stance. This presentation will provide examples of assessment and therapeutic interventions in dealing with suppressed body mentalization.

Learning objectives:

1. Learn how to recognize the inability of body mentalization.
2. Learn about general features of body mentalization-based therapy.
3. Learn about typical interventions of body mentalization-based therapy.

Mentalization among Patients with Severe Psychosomatic Disorders

Lucie Veselka, MA; Martina E.F. Bühring, MD, PhD; Lonneke Prins, MA

Traumatization and Insecure Attachment may suppress the Development of the Ability to Mentalize. The inability to mentalize seems to play an important role in psychosomatic disorders. In our Center patients with severe somatoform disorders are being thoroughly psychologically assessed before intake and treatment. This assessment consists primarily of personality inventories, dissociation questionnaires and the TAT. The SCORS method of Westen (1985, 1991) is being used to assess object relations. Data will be presented of levels of mentalization compared to personality organization (according to Kernberg) of patients with severe somatoform disorders. Research (Eurelings et al. 2005) shows that complexity of representations of people, as measured with the SCORS, increases with the development of personality organization. However, in the case of severe somatoform disorders this is not the case. Mentalization is low when somatization is high, regardless of the personality organization.

Learning objectives:

1. Learning about ways of assessment of severe somatoform disorders.
2. Information about the SCORS method, a way of assessing object relations.
3. Understanding of the important influence of somatization on the ability to mentalize.

Dissociation and Interpersonal Relatedness

Russell Meares, MD

The theme of this presentation derives from a study of borderline personality disorder (BPD), which I conceive as an outcome of chronic traumatization, a term, which includes not only sexual, physical and emotional abuse but also, what Janet called “a succession of slight forgotten shocks.” This presentation has two parts (i) a concept of dissociation is described which derives from the hierarchy of consciousness described by Hughlings Jackson and developed by Janet. This leads to the view not only that BPD phenomena are primarily those of dissociation but also that each form of consciousness in the hierarchy is necessarily interwoven with a particular form of interpersonal relatedness which, linguistic evidence suggests, has features of both disorganization and fusion in the case of dissociation. (ii) the neurophysiological difference between “high-state dissociation” and “low rate-dissociation” is discussed with particular reference to the concepts of “structural” and “somatoform dissociation.” “High-state dissociation” is conceived as the outcome of a compensatory, secondary phenomenon following the initial alteration in consciousness, i.e. Janet’s “lowering of the mental level,” which is understood in terms of the Jacksonian model.

Learning objectives:

1. To become familiar with Jacksonian theory and its relation to Janet.
2. To understand the concept of ‘high-state’ dissociation.
3. To understand the significance of therapeutic relatedness in managing dissociation.

The Older Female Patient with a Complex Chronic Dissociative Disorder

Richard P. Kluff, MD

Dissociative disorders are rarely considered in the diagnostic assessment of older women, despite the fact that the existence, appearance and characteristics of certain dissociative disorders in older populations has been known and described since the 1980s. This communication reviews the core phenomena of Dissociative Identity Disorder and related forms of Dissociative Disorder Not Otherwise Specified, the natural history of their phenomena from youth to old age, and describes common presentations of Dissociative Disorders in older women. It also reviews the treatment of complex chronic dissociative disorders and discusses alternative approaches to their psychotherapy in the older female patient. It is crucial to recognize and respect the importance of appreciating individual differences among older dissociative patients and to individualize their treatments accordingly.

Learning objectives:

1. Describe the spectrum of presentations of dissociative disorders in older women.
2. List considerations in the selection of therapeutic approaches to the older female dissociative disorder patient.
3. Describe differences between the treatment of the older female patients with dissociative disorders from the treatment of younger women with these conditions.

One Eye Integration (OEI): An Innovative & Flexible Therapy for Complex Trauma & Dissociation

Rick Bradshaw, PhD, RPsych.

OEI has similarities to EMDR but has evolved into an entirely different treatment, which complements EMDR and other therapies well (including body therapies). OEI has also been used effectively with complex PTSD and dissociative disorders in couples, groups, with children & families, and with individual adults in addictions. Specialized applications for work with DID and eating disorders will also be addressed. Some OEI techniques provide rapid relief from panic states, nausea, headaches, chest compression, throat constriction, and jaw tension. In addition, negative transference reactions (common among complex PTSD and DID/DDNOS patients) can be cleared. Empirical support for this therapy and neuropsychological foundations promote integration of science and practice. In 3 years of research, the effectiveness of OEI for reducing PTSD symptoms has been demonstrated through randomized clinical trials.

Learning objectives:

1. Attendees will understand the differences between core trauma symptoms and dissociative artifacts as they occur in the process of trauma therapy.
2. Attendees will be able to explain neuropsychological rationales for OEI, and will be familiar with controlled research in which the efficacy of OEI has been demonstrated.
3. Attendees will learn about release points for panic attacks, nausea, and hyperventilation; and learn about procedures to clear negative transference reactions between trauma therapy clients and their counselors.

Preliminary Results of a Naturalistic Study of Treatment Outcome for Patients with Dissociative Disorders

Bethany Brand, PhD¹; Catherine C. Classen², PhD; Ruth Lanius, MD³; Richard J. Loewenstein, MD⁴; Clair Pain, MD⁵; Frank W. Putnam, MD⁶; S. W. McNary⁷

Objective: Although case reports and observational studies suggest that many patients with dissociative disorders (DD) respond to specialized treatment (Coons, 1986; Ellason & Ross, 1997; Kluff, 1986; 1993), there is limited systematic observational research of treatment outcome for DDs. Preliminary cross sectional results of an ongoing naturalistic study using systematic assessments are reported.

Method: Participants were therapists and their patients who were already engaged in treatment prior to the study. At baseline assessment, therapists (N=114) completed a web-based survey on the history and treatment progress of one patient with dissociative identity disorder (DID) or dissociative disorder not otherwise specified (DDNOS). Therapists assessed patients' stage of treatment and rates of self-destructive behavior and hospitalization, and level of adaptive functioning. Eighty-six DD patients completed self-report questionnaires about the above outcomes as well as dissociative and PTSD symptoms, general distress, and substance use.

Results: Therapists' reports suggested patients in later stages of treatment had fewer instances of self-injurious behavior, fewer suicide attempts and hospitalizations, and better adaptive functioning and symptom management. Patients' reports suggested those in later stages of treatment had fewer days of hospitalization than patients in earlier stages.

Conclusions: The results presented are preliminary baseline data from an ongoing pilot study. Treatment delivered by this international community sample of clinicians resulted in between stage differences with small to large effect sizes (η^2 range = .07 - .53). This cross-sectional data suggests that dissociative patients at later stages of treatment show fewer symptoms, less frequent self-destructive behavior and hospitalization, and some signs of more adaptive functioning.

The Use of the Screen Technique

Michaela Huber, Dipl.-Psych.

The screen technique is a most useful tool in working with complex PTSD and dissociative disorders. It helps to find and/or establish one or more observer parts or states that help to explore, distance, communicate, and process difficult affective material including trauma material. Different possibilities for the application are presented, including hints and caveats, e.g.: how to establish a positive calming down imagination by means of the screen technique ("screen saver"); exploring difficult material like conflicts with attachment figures, night mares, self inflicting behavior, amnesias, or flashbacks; and processing trauma material and its pathogenic kernels ("hot spots").

Learning objectives:

1. Describe at least three possibilities to work with the Screen technique;
2. Describe a typical preparation phase for the application of the Screen technique;
3. Distinguish between screening of positive material, difficult material, and processing of "hot spots" (pathogenic kernels).

The Clinical Assessment and Treatment of Trauma-related Self- and Affect-Dysregulation

Annemiek van Dijke, MA

In this workshop a multi-disciplinary “diagnosis and therapy oriented indication” method for patients suffering from trauma-related dysregulation will be presented. Clinically, these patients present themselves suffering from a variety of symptoms. For therapy indication it is crucial to not only diagnose descriptive pathology (DSM axis I and II disorders) but to also consider structural pathology (e.g. personality organization, attachment styles, affect dysregulation styles, somatoform and psychoform dissociation, mentalizing capacities). Illustrated by various patient vignettes, therapy indication and outcome measures will be discussed for assessment and treatment by psychotherapists, creative therapists (music and art), milieu-therapists, and dance therapists. This workshop will focus on facilitating emotional change by recognizing and changing insecure attachment based de-activating and hyper-activating self-regulation strategies in patients. These self-regulation strategies often fail and in turn condition and uphold the insecure attachment representations. Generally, this results in a vicious circle of “insecure cognitive-emotional information processing activating insecure attachment-based de-activating or hyper-activating self-regulation strategies. Moreover, when confronted with internal or external (adverse) events, insecurely regulated persons will never meet the sense of personal efficacy, resilience, and optimism. Using role-play, assessment and treatment techniques will be trained.

Learning objectives:

1. Describe de-activating and hyper-activating self-regulation strategies and understand importance of these phenomena for adequate therapy indication and treatment of attachment traumata related psychopathology.
2. Apply instruments and techniques for therapy-oriented indication procedures
3. Describe the attachment trauma-related self-dysregulation and affect-dysregulation treatment plan

The Joint Use of EMDR and Hypnosis in the Treatment of DID, DDNOS and Complex PTSD

Catherine Fine, PhD

Dissociative Identity Disorder (DID), a chronic childhood onset posttraumatic stress disorder (PTSD), is currently recognized as a treatable condition. It is considered the paradigmatic dissociative disorder and carries with it extreme posttraumatic symptomatology which lends itself to be an apt target for treatment combining the use of EMDR and hypnosis. Therapists skilled in the treatment of DID and Dissociative Disorder Not otherwise specified (DDNos) have augmented their therapeutic arsenal with the fluent uses of hypnosis for stabilization, affect management, building a safe place and grounding. EMDR, which has come to the forefront of clinical awareness in the last fifteen years, seems well suited for the treatment of trauma, but can be destabilizing. The presenters recommend a protocol, called Wreathing Protocol, for the imbricated use of EMDR and hypnosis in the treatment of not only DID, but also DDNOS and complex chronic PTSD. The Wreathing Protocol is useful to advanced clinicians skilled in both modalities independently. This workshop will explain and illustrate with a clinical vignette the sequential steps of the Wreathing Protocol; it will describe the required contextual treatment frame for its safe use. The presenters will explore the consequences of the premature uses of EMDR and offer playful structured responses to a disequibrated treatment and a destabilized patient. The clinical implications of the use of the Wreathing Protocol will be discussed.

Learning objectives:

1. Name three prohibitions to the use of EMDR in the treatment of dissociative disorders.
2. Exemplify one target symptom of the BASK model of dissociation in the clinical example presented and relate a different one in one of your own patients.
3. Describe a potential multistep Wreathing Protocol sequence from selection of target to resolution of at least one microsymptom in a patient of your choice.

Broken Bonds: A Sensorimotor Approach to Attachment, Trauma and the Body Pat Ogden, PhD

Traumatic experience leaves behind not only a legacy of posttraumatic symptoms but also a burden of fear and mistrust that affects all future relationships, including the therapeutic one. Instead of experiencing therapy and the therapist as a haven of safety, the traumatized client will be driven by powerful wishes and fears of relationship that compromise therapeutic work by causing autonomic dysregulation and activating animal defensive responses. Recent studies highlight the importance of early non-verbal, body-based, intersubjective communication between child and caregivers as determinants of affect regulation capacities and procedural memory, shaping the template for future relational interaction. This workshop will explore the influence of procedural learning on adult relationships, the impact of trauma and attachment failure on adult attachment behavior, and address working at the regulatory boundaries of the window of tolerance as the patient's arousal begins to challenge his or her integrative capacity. The use of directed mindfulness to enhance affect regulation will be emphasized and non-verbal interventions that promote adaptive intimacy, attachment and affect regulation will be taught. Interventions and concepts will be discussed and illustrated through lecture, video excerpts of sessions with patients, and brief experiential exercises, and handouts.

Learning Objectives:

1. Participants will be able to describe non-verbal, procedural manifestations of disorganized attachment behavior and its implications for treatment
2. Participants will be able to describe the theory and practice of Sensorimotor Psychotherapy
3. Participants will be able to utilize Sensorimotor Psychotherapy techniques to address attachment issues in psychotherapy

Disorders of Extreme Stress: Clinical Phenomenology, Effectiveness, and Neuroimaging

Chair: Nel Draijer, PhD

First the clinical phenomenology of disorders of extreme stress will be analyzed. Both a strong overlap of symptoms is associated with the three diagnoses C-PTSD, BPD, and DID, and specific symptom traits can be identified as typically discriminating between these diagnoses. Then the participant will be informed on the Dutch Complex PTSD Research Project as it is conducted since 2002 at the Department of Psychiatry of the Vrije University Amsterdam. It consists of a multi-site RTC on the effectiveness of a stabilizing (Phase I) group intervention for women with complex PTSD after child abuse, as well as fundamental research on (changes in) brain activity in Complex PTSD. The focus will consecutively be on: 1) clinical phenomenology of extreme stress related disorders; 2) stabilizing group treatment for Complex PTSD; 3) its effectiveness, according to a pilot (open study) and the first preliminary RCT data; and 4) differences in brain functioning and memory, using neuro-imaging (fMRI), between patients with complex PTSD after child abuse and healthy controls.

Learning objectives:

1. Acquire an overview of the current questions considering the diagnosis of extreme stress related disorders
2. Get an overview of the content and effectiveness of a stabilizing group treatment of Complex PTSD (phase I) and an impression of stabilizing techniques.
3. Describe the neurobiology of complex PTSD using neuro-imaging; define brain areas of interest in the study of (complex) PTSD and memory; discuss the relation between symptoms, memory performance and perfusion changes in the brain.
4. Evaluate discrepancies in findings concerning memory in (complex) PTSD

Complex PTSD, Dissociative Disorders and Borderline Personality Disorder – Towards a Common Concept of Disorders of Extreme Stress

Martin Sack, MD; Bettina Overkamp, PhD; Birger Dulz, MD; Ulrich Sachsse, MD

From a clinical viewpoint, a commonly accepted diagnostic concept for disorders of extreme stress is urgently needed. Aim of our study was to determine the diagnostic overlap between Complex PTSD, Dissociative Disorders and BPD and to investigate symptom patterns discriminating between these diagnoses.

In a six-site multicenter study a total of 274 participants (73% female) were assessed. DESNOS criteria were assessed with the German version of the Structured Clinical Interview for Disorders of Extreme Stress (SIDES). The International Personality Disorders Examination (IPDE) served as diagnostic interview for BPD and the DDIS was used for the assessment of Dissociative Disorders.

148 (54) of all participants fulfilled diagnostic criteria for BPD and 289 (69%) for Complex PTSD and 33% (89) for cDD. A very high diagnostic overlap was found: 80% of all patients fulfilling criteria for BPD also were classified as having Complex PTSD. Over 40% of all patients fulfilling criteria of Complex PTSD also were diagnosed with cDD. Discriminant analysis using questionnaire data showed antisocial and impulsive personality traits to be significantly associated with BPD whereas avoidant and obsessive-compulsive personality traits, somatoform symptoms and depressive symptoms were associated with Complex PTSD and cDD.

Our results give evidence for a strong overlap of symptoms associated with all three diagnoses. At the same time some specific symptom traits could be identified as typically discriminating between diagnoses. The idea of differentiating a subtype of chronic PTSD more associated with externalizing (BPD) from a subtype more associated with internalizing behavior is supported by our results.

Stabilizing Treatment Protocol for Phase I Treatment of Complex PTSD
Ethy Dorrepaal, MD; Kathleen Thomaes, MD; Nel Draijer, PhD

Especially after interpersonal traumatization in childhood PTSD symptoms - re-experiencing, numbing and hyper arousal - may be complicated by personality changes such as disturbed affect regulation, memory, self-image and relational problems. This syndrome has been labeled 'PTSD with associated features' in DSM-IV-TR and is known by clinicians as 'complex PTSD' or 'Disorders of Extreme Stress NOS'. It is often associated with severe psychiatric symptoms, high morbidity, social maladjustment and tends to run a chronic course in spite of considerable use of medical and psychiatric services. We translated and adapted a stabilizing (phase I) treatment manual of C. Zlotnick to cover all domains of Complex PTSD diagnosis by focusing on decreasing the core symptoms by increasing cognitive control over symptoms and enhancing skills. We will present the manner this treatment is conducted and the content of the treatment sessions.

What are the Effects of a Stabilizing Group Treatment on Complex PTSD? Preliminary Data of a Multi Site RCT

Ethy Dorrepaal, MD; Kathleen Thomaes, MD; Jan Smit, PhD; Ton van Balkom, MD, PhD;
Nel Draijer, PhD

Complex post-traumatic stress disorder resulting from childhood abuse, includes not only PTSD symptoms - intrusions, avoidance and hyper arousal - but also affect dysregulation, problems in consciousness, self-esteem, in relationships, meaning and somatization. The clinical specialist literature expresses preference for stabilization (Phase I) treatment over exposure, but empirical evidence is still scarce.

We translated and extended a treatment protocol developed by Zlotnick (1997). This stabilizing group intervention focuses on decreasing the core symptoms of complex PTSD by increasing cognitive control over symptoms and enhancing skills. Our pilot results (N=36) pointed towards the feasibility and effectiveness of both treatment and study. Objective: To investigate the effects of a stabilizing treatment in a clinical heterogeneous female C-PTSD population.

Method: A Randomized Controlled Trial, conducted (2005-6) in 4 regional outpatient clinics in Holland.

Results / conclusion: First analyses point to the effectiveness and clinical relevant changes in complex PTSD patients after and preliminary results of our RCT will be presented, as well as data on co-morbidity.

Neurophysiological Correlates of Complex PTSD

Kathleen Thomaes, MD; Ethy Dorrepaal, MD; Nel Draijer, PhD; Michiel de Ruiter, PhD; Bernet Elzinga, PhD; Ton van Balkom, MD, PhD; Jan Smit, PhD; Dick Veltman, MD, PhD

Objective: In order to gain insight in the core symptoms of complex PTSD - particularly affect dysregulation and declarative memory disturbances, apart from established PTSD symptoms - this project investigates the neurophysiological correlates of these symptoms.

Method: A case-control study was performed in 32 C-PTSD patients and 32 non-traumatized healthy controls. Patients were selected from the C-PTSD participants in the Randomized Controlled Trial. Criteria for selection were: no metal, not pregnant, no psychotropic medication other than SSRI. Using functional MR Imaging, regional perfusion differences were assessed during performance of a verbal declarative memory task, with neutral and trauma related words. Both performance (reaction times and error rates) and perfusion changes in limbic regions are compared. In addition, analyses of covariance will be conducted to investigate the role of symptom severity.

Results/ conclusion: Differences in activity in the hippocampus and anterior cingulate gyrus have been found in complex PTSD patients vs. healthy controls while performing a declarative memory task during functional MRI.

Phase I Preparations of Severely Traumatized Women for Exposure by Extended EMDR-Protocols in Phase II Treatment

Anna Gerge, Leg. Psykoterapeut

This presentation offers a description of an integrative approach of group treatment within phase I treatment leaning on psychodynamic theory, a clear psycho-educative approach that uses methods as hypnosis/relaxation training/mindfulness training, aims for enhanced relational capacity and self-regulation by using hypnotic techniques aiming at enhanced containment capacity (Brown & Fromm, 1986; Kluft, 1993, 1999; Phillips & Fredericks 1995; Chu 1998; Cardeña et al., 2000). The treatment aims at enhanced capacity to mentalize, i.e., using the reflective functions in self-organization (Fonagy, 1997). This is considered to offer the participants an enhanced "self soothing capacity" (Krystal 1988a,1988b), i. e., the capacity to calm and soothe the self by enhanced self regulation and capacity to rest, by helping the participants to reach experiential states where they can contain their own reactions, as well as offering training in order to tolerate and understand the signals of the body, i. e. the "felt sense" (Gendlin, 1978; Ogden, Minton, & Pain 2006). The trauma therapy within phase II-work by extended EMDR-protocols is exemplified with special focus on the restoration of the capacity for adequate self-care as well as care-giving functions.

Learning Objectives:

1. To show how an integrative group treatment in phase I treatment can be used in trauma therapy for stabilization with patients with complex PTSD and high levels of dissociation (psychoform and/or somatoform co-morbidity).
2. Exemplify trauma-therapy within phase II work by extended EMDR-protocols addressing the special needs of continuous reinforcement of stabilization for the same population.
3. Focus on restoration of the capacity for adequate self-care as well as care giving functions.

A Mutual Aid Support Group for Persons with AIDS in Early Substance Abuse Recovery Who Have Experienced Early Childhood Trauma Impacting Affect Regulation, Sense of Self and Social Relations

Lawrence Shulman, MSW, EdD

The presentation describes and illustrates in detail the presenter's co-leadership of a mutual aid support group of five members all of whom have experienced childhood trauma resulting in a negative impact on their affect regulation, sense of self and social relations. The group members – one gay male, one transgender women, two heterosexual African American males and one heterosexual woman with ages ranging from 20 to 35 have all self-medicated with alcohol and a range of drugs and have engaged in risky sexual activity including prostitution and/or casual and unprotected sex. The purpose of the one-year group was to explore the impact of AIDS on their recovery and the impact of their recovery on their struggle with AIDS. The content and process of the group will be illustrated through detailed process records dealing with the development of the group-as-a-whole, the changing culture of the group, and the way in which the mutual aid process itself helped members to deal with their "internalized oppressor" resulting from early traumatization. Members are helped to rediscover interpersonal skills for creating new attachments based upon caring rather than the exploitive behavior, which characterized their more recent lives. The concept of time and the phases of work – preliminary, beginning, middle and ending/transition – is used to organize the presentation over the life of the group as well as individual sessions. The specific healing powers of the mutual aid approach will be described by the presenter, one of the founders of this approach in the social work profession.

Learning Objectives:

1. To describe and illustrate the mutual aid group process as a means for treating persons who have experienced early childhood trauma, which has impacted, affect regulation, sense of self and social relations.
2. To describe and illustrate the application of a mutual aid group process to persons with AIDS in early substance abuse recovery.
3. To describe and illustrate the phases of work (preliminary, beginning, middle and ending/transitions) and the mechanisms of change in a mutual aid group.

The Impact of an Intensive Outpatient Program on Attachment Style among Chronically Traumatized Women

Catherine C. Classen, PhD; Robert T. Muller, PhD

Objective: While research has examined the relationship between attachment and psychopathology among adults with trauma histories, research is needed on the impact of psychological treatment on attachment style. The Women Recovering from Abuse Program (WRAP) is an innovative and intensive, Stage 1, 8-week, outpatient program for women with histories of chronic child abuse and neglect. This study examines whether WRAP can alter attachment style and whether change in attachment style is reflected in change in PTSD symptoms, interpersonal problems and dissociation.

Method: Thirty-four women were assessed at baseline and again immediately following completion of WRAP. Attachment style was assessed using the Adult Attachment Projective, a relatively new method that is highly correlated with the Adult Attachment Interview. Participants also completed the Post-traumatic Checklist, the Inventory of Interpersonal Problems and the Dissociative Experiences Scale.

Results: Thirty-one women were insecurely attached with 23 being unresolved in attachment style. Approximately, 23% of the insecurely attached women improved in attachment style. Those who improved in attachment style showed a greater reduction in PTSD symptoms, interpersonal problems and dissociative experiences.

Conclusions: Although attachment style is generally thought to be enduring, this study suggests that even a brief intensive treatment can positively affect attachment style and that this improvement in attachment is consistent with change in other symptoms.

One Solution Focused Way of Working with Dissociative Persons

Hélène Dellucci, Psychologist

Dissociated clients are often those, with whom the contact can be complicated, establishing stable supportive relationship can be a real challenge. Especially when feelings of despair and helplessness are strong, how can the therapist manage to remain solution and resource focused and encourages clients to stay hopeful? Could a way of doing therapy prevent professionals from burnout? Some leads are given by the use of the main concepts of the solution focused brief therapy (Isebaert; De Shazer) and their special use with dissociated clients, linked to some ideas inspired by the autopoiesis theory of Maturana and Varela and more recent research in social psychology (Snyder). This workshop aims to present some theoretical patterns linked to practical topics in the work with many clients and especially dissociated clients.

Learning objectives:

1. Responding to the existential dimension of the client
2. Getting aware of how our way of looking on the client influences him (the minimalistic social influence with a huge effect)
3. The fastest way of building a supportive relationship with two kinds of expertise

Rebuilding the Self-Structure: Using Time as a Neural Organiser

Nel M. Walker, psychologist / psychotherapist

Disorders of time are ubiquitous in clients with damaged self-structures, such as those with dissociative disorders. The author will present a simple model of self-structure illustrating how the experience of continuity through time, especially in developmental years, is a vital neural organiser leading to a flexible and coherent sense of self. She will describe how therapy focused on this 'organiser', facilitates profound and relatively rapid healing in a gentle way to those suffering from Complex PTSD and Dissociative Disorders. Aware for many years of the significance of time disorders in traumatised clients, the author was pleased to come across the work of Peggy Pace, who has been developing 'Lifespan Integration' based on the neuroscience of integration, since 2002. The author will describe how Lifespan Integration links with the above-mentioned model, providing a method of clinical practice facilitating the development of a more coherent, cohesive and integrated self-structure, thus giving the client a much stronger sense of self in the present. She will also describe how it leads to the integration and 'realisation' of dissociated traumatic memories even in clients with tertiary structural dissociation (Van der Hart, Nijenhuis, & Steele 2006), thereby reducing or even eliminating symptoms in the present.

Learning objectives:

1. To demonstrate the significance of the sense of continuity through time as a neural organiser
2. To describe how therapy can harness 'time-tagging as a neural organiser, thereby resolving dysfunctionally stored 'time-stuck' memories.
3. To show how the practice of 'Lifespan Integration' makes effective use of time as an organiser leading to a more integrated self-structure across the whole range of mental health problems that are caused by lack of sufficient integration.

Imagery Rescripting: Reprocessing Therapy in combination With a protocol for Psychomotor Therapy

Paula de Jong, MA; Marja Zwart, MA

Imagery rescripting is an imagery-focused treatment designed to alleviate PTSD symptomatology and alter abuse-related beliefs and schemas (e.g. powerlessness, victimization, inherent badness, unlovability) of survivors of childhood sexual, mental and physical abuse. The procedure combines imaginary exposure (visually recalling and reexperiencing the images/thoughts and associated affect of the traumatic event) imagery rescripting (changing the abuse imagery to produce a more favorable outcome). The aim of rescripting is to replace victimization imagery with mastery imagery, thus enabling the abuse victim to experience herself responding to the abuse scene as an empowered individual no longer “frozen” in a state of helplessness. Through this imagery psychodrama, the recurring victimization imagery is modified and the maladaptive schema’s underlying abuse-related cognitions are identified, explored and challenged. In some circumstances the discrepancy between the trauma and prior assumptions is too great, emotional processing of trauma information will be chronic. Emotional processing may be prematurely inhibited due to sustained efforts to avoid the reactivation of highly distressing information. We hypothesize that nonverbal techniques can help the patient to focus on the sensory-specific systems and remove the avoidance tendency.

Learning objectives:

1. Understand the information processing theory of PTSD (Foa, Lang), the dual representation theory (Brewin) and the SPAARS model (Schematic Propositional Analogical Associative Representation Systems, Power and Dagleish).
2. Explain IRRT
3. Show video fragments of treatments with PTSD and DID patients.

Receptive Music Therapy: Guided imagery and Music (GIM), in Phase II Treatment for Women with Complex PTSD and DESNOS

Gabriella Rudstam, MA, Lic Psychotherapist

The presentation will offer a description of GIM and how it can be used in the work of healing trauma and attachment wounds in severely traumatized patients. The presentation will be experiential. Participants will have the opportunity to follow case(s) where GIM techniques are used for both stabilization and trauma-therapy work. Imagery will be shared together with the music used in GIM sessions, for a deeper understanding of the therapeutic process. The presenter will also show artwork done by the patient(s) in sessions.

Learning Objectives:

1. Show and share how GIM can be used to enhance the integration and healing in severely traumatized patients.
2. Familiarize the audience with examples of the music used in GIM and the artwork produced by patients during GIM.
3. Understand how GIM is used in both the stabilization phase of treatment and the trauma-therapy work.

Therapist's Use of Oneself to Integrate the Many Selves of the Patient with DID

Rachel Gunner, MSW

Relationship building is a fundamental element to the success of the therapeutic process. This presentation will examine the key components of a helping relationship that enabled Hanna, one woman with 26 personalities to become whole in less than two years. The goal of this talk is for the practitioner to evaluate his own therapeutic underpinnings and to encompass a humanistic intervention that the author has labeled a model of "elasticity" which includes availability beyond the 50 minute hour, flexibility, mutual respect, shared learning, ability to listen to one another, therapist self-disclosure, honest caring, hope, optimism and faith. Therapist's use of self is the crucial element in building trust, which is the cornerstone of the healing process. The presentation offers one solution for treating persons with DID with dignity that promotes long term healing in a remarkably short period of time. As Hanna says, "When therapy is bad, it can be a trap; when it is good it can set one free."

Learning Objectives:

1. To incorporate the principles of "elasticity", or the therapists "use of self" in a professional therapeutic relationship
2. To understand the rationale for using oneself as a therapeutic tool
3. To challenge the practitioner to move beyond professional walls without loss of professional integrity

The Adult Attachment Inventory (AAI) as a Therapeutic Intervention with a Patient with DDNOS: A Spanish Case Report

Olaf Holm, MD

In this presentation, the therapeutic use of the AAI is illustrated by the case example of a middle-age woman with a history of severe physical abuse and diagnosed with DDNOS using the SCID-D. She also suffered many symptoms related to complex traumatization, including negative somatoform dissociative symptoms (transient blindness and acute collapse). She had a history of continuous and severe attachment disruptions in the relationship with both her mother and father. At the end of assessment with the AAI, subjects are questioned as to whether they consider any experiences as setbacks to their development and how, overall, experiences may have affected their present personality. In this case example, the AAI was administered within the context of a phase-oriented treatment approach; in particular in Phase 1, when the therapeutic focus was on overcoming the phobias of trauma-derived mental actions and of dissociative parts. By then, the patient's mental level had increased to such a degree that the AAI could also be used to explore and subsequently resolve negative core beliefs such as "I am not worth living", "Better dead than in her hands", "I can't get away from her, she is my mother". These core beliefs could then be used as cognitive bridges to past traumatic experiences, related to the most dangerous symptoms (e.g., serious suicide attempts and serious self-harm) that were subsequently resolved. Provided that the clinician has at least a basic understanding of the AAI, this approach might seem applicable in various other cases as well.

Learning objectives:

1. To recognize how AAI may help the patient to attune to negative core beliefs, which may constitute the point of departure for the treatment of traumatic memories.
2. To be aware how increasing integrative capacity heightens the ability to overcome the phobias of trauma-derived mental actions and/of dissociative parts.
3. To learn how the development of positive beliefs need to be accurate and relate to different aspects of the traumatic memories.

Clinical Implications of “Integrative Theory of Dissociation”

Joan Lesley, MA

Dynamic and cognitive conceptualisations of unknown/forgotten experience are traditionally expressed in the phenomena of repression, splitting, dissociation and defence. The theory presented here aims at increasing consensus between the two conceptualisations at the theoretical level, founding from this consensus understanding at the clinically expressive level and lastly, developing therapeutic interventions for phenomena which exclude experience from awareness (dissociation). The integrative theory of dissociation describes a cognitive organisation of experience based on the premise of awareness as being relative, contingent on the activated representation of the ongoing event being linked to the activated self-representation. The cognitive structure allows for four integration variations wherein experiential meaning is the organising factor and allows for active defence. The organisation of experience within this structure is reflected clinically in a 4-part model of dissociation: i) non-integrated experience-perceptions about an object/event and the reaction are not integrated into the activated self-representation but remain at the sensory level; ii) alternatively integrated experience—experience is integrated into a specific, limited active self-representation; iii) disintegrated experience—unvalidated, unacceptable, or traumatic experience concerning ongoing, innate drives and needs is no longer consistently activated in the core self-representation; iv) variably integrated experience—activation of specific information blocks other specific information. Clinical implications of integrating experience organised on the basis of the idiosyncratic experiential meaning includes the significance of uncovering and altering meaning while taking the origin of the event into account and regulating emotions.

Learning objectives:

1. Gain an understanding of dynamic defence phenomena as expressions of dissociation.
2. Gain an understanding of the significance of the origin of the dissociated event for the treatment process.
3. Increase understanding of the significance that the meaning the patient has invested in the event has for the integration process.

Traumatic Experience, Cartesian Dualism, and the Theory of Structural Dissociation of the Personality

Anssi Leikola, MD

The theory of structural dissociation of the personality has already shown to be a powerful tool to evaluate and diagnose traumatized patients. It gives a distinct valuable frame for clinical practice. Through this frame we are able to search relevant information in new ways, differentiate and synthesize this information, in order to plan and execute phase-oriented treatment of trauma survivors. However, philosophical analysis of the basic concepts and underpinnings of the theory seems to be relevant and important in order to better understand the interrelated features of trauma and psychopathology. In trauma research and clinical practice, we need to go beyond dualism and reductionism, towards a more holistic theory, in order to understand the complex phenomena of trauma-related psychopathology. In this workshop the long held scientific assumption of Cartesian dualism, for instance, is once more critically questioned. The scientific study of trauma naturally reveals the intimate connection of mind and body. This picture seems to become even clearer when we use Pierre Janet's classical concept of dissociation. The discrepancy (i.e., incommensurability) between different frameworks or approaches underlying scientific actions raises philosophical questions that need to be investigated: In order to understand the difficulties which are clearly in the way of integrating an overall picture of trauma. An alternative way, beside Cartesian dualism, of solving the mind-body-problem is studied: the concept of evolutionary based hierarchical model, forming one basic assumption for many of the most interesting theories concerning about what is the essence of trauma.

Learning objectives:

1. Becoming more informed about philosophical questions closely related to the aim of study trauma properly and more efficiently. For example, understanding how all scientific study always has a place within some philosophical framework, i.e., it is based on some theoretical assumptions, and how important is to become aware of this fact and its effects on understanding the results.
2. Becoming informed about how trauma research reveals that mind and body are closely linked/connected with each other in many ways.
3. Understanding how holistic and hierarchical theories provide a different and deeper understanding of traumatization than dualistic and reductionistic assumptions and theories.

Effective Physical Enactments and Scenarios for Treating Dissociative Patients

Ralf Vogt, PhD; Irina Vogt, Dipl.-Psych.

Dissociative patients are frequently reactive to triggers and experience-debilitating somatoform complaints. A body centered approach to psychotherapy can be particularly useful for calming the body, resolving traumatic memories and facilitating integration. This workshop will explain the theoretical background and effectiveness of specialized designed sculptures developed 12 years and studied with 76 patients. These so-called *Beseelbare* therapy objects are symbolic projections or representations that can have dynamic meaning or interpretation for dissociative patients. We will illustrate with the use of DVDs how these powerful representations can be used in a variety of enactments with the dissociative child or adult in individual and group therapy to facilitate bodily awareness, to release the traumatic energy causing physical discomfort, and gain a sense of empowerment and mastery over the events. We will also describe how this complex method combines playful and serious interventions, including elements of psychodrama, Gestalt Therapy and psychoanalytical approaches. The participants of the workshop will explore some settings of this approach and discuss their experiences. Body-oriented method helps traumatized patients to cope with their physical discomfort.

Learning objectives:

1. Define the complexity of body centered interventions in psycho-trauma therapy.
2. Discuss how a body oriented approach helps to find new ways of symbolism in dissociative disorders.
3. Describe how body centered interventions can be utilized to increase integrative capacity.

Attachment-based Intervention Programs to Prevent Transgenerational Trauma:
Karl-Heinz Brisch, MD; A. Driessen, MD

Two attachment-based intervention programs SAFE and B.A.S.E. were developed in Germany. Their major aims are to promote the infants' development of secure attachment and to enhance parental sensitivity for infants' needs, and to reduce aggression and anxiety, especially the transgenerational re-enactment of violence. SAFE starts early in pregnancy and guides parents in group meetings and individual trauma-oriented psychotherapy till the end of the first year of their infant. B.A.S.E. is training for children in kindergarten and schools that uses mother-infant observation to promote sensitivity for the infant's signals. The evaluation shows that children are less aggressive, less anxious, but more attentive and prosocial after one year of B.A.S.E. training. In the workshop the aims and the implementation of SAFE and B.A.S.E. groups in Germany and New Zealand are discussed and the key concept of sensitivity training is demonstrated with video-clips.

Learning objectives:

1. To define theory, contents and models of preventive programs SAFE and BASE
2. To learn to do a video feedback sensitivity training
3. To learn how to implement both programs in different countries (e.g. Germany and New Zealand)

Anger Management and the Trauma Patient

George F. Rhoades, Jr., PhD

Participants will be introduced to the current literature on anger, anger and the trauma/dissociative patient, and anger management. Participants will be introduced to and interact with the presenter on ten different coping skills to help patients better manage anger within the context of group and/or individual therapy. The ten coping skills to help patients better manage anger will be presented and discussed include 1) Understanding your anger, 2) Empathy, 3) Self-Talk, 4) Relaxation Skills, 5) Use of Humor, 6) Time-Out Procedures, 7) Assertiveness Training, 8) Communication Skills, 9) Problem-Solving, and 10) Forgiveness. The application of the program will be discussed for both the individual and group therapy format for children, adolescents and adults.

Learning objectives:

1. Participants will gain an understanding of the assessment of anger with an emphasis on the trauma patient.
2. Participants will be familiarized with an overview of the current literature on anger management and the trauma patient.
3. Participants will gain an understanding of anger management with trauma patients, involving possible dangers and benefits of anger management coping skills presented.

What to do if the Mother of a Dissociative Child has Disorganized Attachment

Sandra Wieland, PhD

Children cannot be worked with in isolation. They are part of a family system and often, in the case of foster or adopted children, part of several family systems. The importance of working with the family or families, in particular the mother figure is even greater for children who dissociate. This workshop will describe work with mothers around safety, stability, addressing dissociation, and increasing positive family interaction. This work is particularly challenging when the mother (birth, foster or adoptive) experiences a disorganized attachment pattern. This attachment pattern needs to shift in order for the child to experience the stability necessary for permanent integration. Ideas for working with mothers with disorganized attachment patterns will be discussed. Techniques for working together with the mother and child as they acknowledge early trauma, discuss present positive and negative situations, and notice emotions and body sensations. Several case studies will be presented. Discussion will include helping mothers (1) recognize repetitive negative family dynamics and shift them, (2) recognize triggers and help children de-potentiate the triggers, (3) recognize and resolve their own attachment issues, and (4) interact with their children in a way that encourages integration of the dissociated parts.

Learning objectives:

1. Identify areas, which need to be considered when working with families of children who dissociate.
2. Describe ways to help parents move out of a disorganized attachment style.
3. Teach parents and children to process together experiences, emotions and body sensations.

Dissociation and Psychosis

Chair: Andrew Moskowitz, PhD.

Discussant: Mark van der Gaag, PhD

The interface between dissociation and psychosis is a complex and multifaceted one, which will be explored from historical, empirical, and clinical perspectives in this symposium. Beginning with an historical discussion of what is meant by the terms *dissociation*, *psychosis*, and *schizophrenia*, presenters will offer dissociative explanations for psychotic symptoms, explore cognitive processing in dissociative and psychotic disorders, and discuss issues of comorbidity and misdiagnosis in patients presenting with both psychotic and dissociative symptoms. Models addressing the overlap between dissociation and psychosis will be proposed and debated.

What is Dissociation and What is Psychosis? An Historical Examination

Andrew Moskowitz, PhD

The more we know about dissociation, the less sure we become about what psychosis is. In this talk, the concepts of dissociation, psychosis, and schizophrenia – from Bleuler to the DSM-IV – will be explored in their historical contexts, and dissociative explanations for psychotic symptoms proposed. Objective: Audience members will be able to trace the historical development of the concepts of schizophrenia, dissociation, and psychosis, as well as potential links between dissociation and psychotic symptoms.

Dissociation and Psychosis: An Examination of the Cognitive Experimental Literature

Martin J. Dorahy, PhD

This paper will explore the experimental research examining cognitive processing in dissociation and psychosis. Particularly emphasis will be given to attentional mechanisms, such as cognitive inhibition, as these have been studied to a greater or lesser degree in dissociative and psychotic samples and therefore provide a vantage point to examine disjunctions and convergences. Objective: Audience members will appreciate potential significant differences between psychotic and dissociative disorders in cognitive mechanisms, particularly those involving attentional systems.

Dissociation in Patients with Schizophrenia: Relationships with Childhood Trauma and Psychotic Symptoms

Ingo Schäfer, MD; Barbara Reitemeier; Liv Langer; Volkmar Aderhold, MD; Timo Harfst, PhD

Objective: Only few studies have investigated the relationship between childhood trauma and dissociative symptoms in patients with schizophrenia spectrum disorders. Moreover, most of the existing studies did not pay attention to potential relationships between dissociation and psychotic symptoms.

Methods: We examined 103 consecutively admitted patients with schizophrenia spectrum disorders using the Childhood Trauma Questionnaire (CTQ), the Dissociative Experiences Scale (DES) and the Positive and Negative Symptom Scale (PANSS). Relationships between dissociative symptoms, childhood trauma and psychotic symptoms were examined at admission (t0) and when patients were stabilized (t1).

Results: In our sample, substantial rates of childhood trauma were found (CTQ total score: M=50.2, SD=14.9; Sexual abuse: M=7.2, SD=4.2; Physical abuse: M=7.4, SD=3.4; Physical neglect: M=10.0, SD=3.5; Emotional abuse: M=11.7, SD=5.3; Emotional neglect: M=14.2, SD=5.2). The DES mean score decreased significantly between t0 and t1 (M=20.1 vs. M=14.5). When patients were stabilized, sexual abuse, physical abuse, emotional abuse and the CTQ total score were significantly correlated with the DES total score ($r=.36^{**}$, $r=.20^*$, $r=.28^{**}$, and $r=.32^{**}$) and different subscales of the DES, most strongly with the amnesia subscale. The amnesia subscale of the DES also showed significant correlations with physical neglect ($r=.28^{**}$). At t1, positive symptoms as measured by the PANSS were correlated with the depersonalization subscale of the DES ($r=.24^*$). No relationship existed with negative symptoms.

Conclusions: Our results confirm the relationships between childhood trauma and dissociation in patients with schizophrenia spectrum disorders. Furthermore, they suggest a relationship between dissociation and positive, but not negative psychotic symptoms.

The Relation between Psychotic and Dissociative Disorders: Comorbidity or Continuity?

Vedat Şar, MD

Many authors believe that Bleuler's diagnostic criteria for schizophrenia were so broad that they led to the misdiagnosis of dissociative disorder patients as psychotic. The diagnostic criteria for schizophrenia in DSM-IV include symptoms (e.g. hallucinations, Schneiderian symptoms), which may also occur in somewhat different form in dissociative disorders, and patients with psychotic disorders and a history of childhood trauma may also experience dissociative symptoms. Several hypotheses have been proposed to explain this phenomenon. These include a continuity hypothesis and a proposed dissociative subtype of schizophrenia. An integrated approach based on comorbidity and an interaction between two distinct psychopathologies is proposed here, which may lead to an improved understanding of patients presenting with mixtures of dissociative and psychotic symptoms. Objective: Audience members will be exposed to several competing ways of understanding symptom overlap between dissociative and psychotic disorders, including an approach based on both comorbidity and an interaction between two distinct psychopathologies.

Frequency of Dissociative Disorders Among Psychiatric Inpatients in an Iranian Clinic

Hossein Baghooli, MA; Ghasem Naziri, PhD; Cyrus Sarvghad, PhD

Objective: The aim of this study was to determine the rate of dissociative disorders among psychiatric inpatients in a university clinic in Iran.

Methods: The Dissociative Experiences Scale was used to screen 166 consecutive inpatients admitted to the psychiatry clinic of a university hospital. The patients who had scores higher than 30 were matched for age and gender with 19 of the patients who scored below 10 on the scale. The patients in both groups were then interviewed with the Dissociative Disorders Interview Schedule by interviewers who were blind to their diagnoses and scores on the Dissociative Experiences Scale. Patients who were diagnosed as having a dissociative disorder according to the Dissociative Disorders Interview Schedule were then interviewed by a clinician.

Results: Twenty-four (14.5%) of the 166 patients had a score higher than 30 on the Dissociative Experiences Scale; 17 patients (10.2%) were diagnosed as having a dissociative disorder according to the Dissociative Disorders Interview Schedule. Nine patients (5.4%) had clinically confirmed dissociative identity disorder.

Conclusions: A considerable proportion of the psychiatric inpatients in an Iranian university psychiatry clinic had dissociative disorder. Clinicians who work in general psychiatric inpatient units should be alert for chronic complex dissociative disorders.

The Effect of Socio-cultural Diversities on Dissociative Experiences

Mohsen Kianpoor, MD; Mohammad Bahredar, MA; Mohsen Yazdan-Mehr, MD

Objective: Dissociation as a neurotic defense mechanism that changes feeling, identity and cognition of a person temporarily, to avoid emotional distress, has been shown to be a defense against psychological trauma or extra psychic stressful events. The goal of this study was to test if there is a difference in rate of experiencing dissociative phenomena in societies with different cultural characteristics and as a result different level of proneness to stressful events or not.

Methods: We compared A-DES score of four groups of high school students in four major residential areas of Shiraz (capital city of Fars province in Iran) and one group of students in Fassa (a small town in Fars). We used random cluster sampling and each group was consisted of 100 high school students (age 15-17). All of the 500 students filled A-DES questionnaire anonymously.

Result: The results showed a higher average of A-DES score in Faso students (3.34), than the students in Shiraz (2.85). The difference was meaningful ($p < 0.009$) when using t-test for comparing the groups living in different societies. There was no significant difference between average of A-DES score in groups with different age or sex.

Conclusion: Higher frequency of dissociative experiences in students living in a small city with more traditional way of life can be indicative of a probable relationship between socio-cultural characteristics and applying dissociation as a defense to psychological trauma. However, dissociation itself might be seen as a culturally dependent pattern of behavior in such societies.

Gender, Attachment Styles, Traumatic Events, Life Events, and PTSD in all Faroese Eighth-Grade Students

Tora Petersen, PhD; Ask Elklit, MSc, J.G. Olesen

Background: After exposure to traumatic events, having a secure attachment style is generally associated with decreased levels of Post Traumatic Stress Disorder (PTSD), whereas insecure attachment styles are associated with enhanced levels of PTSD. However, little is known about these associations in youth populations. Objectives: To examine the relationships between gender, PTSD, and attachment style in a youth population and the relationships between various traumatic events, negative life events, and attachment. Method: All Faroese eighth-grade students ($n = 687$, $M=14.2$ ($SD=2.1$ years)) filled out the Revised Adult Attachment Scale, The Harvard Trauma Questionnaire-Part IV, and a list of traumatic events and negative life events. Results: Males had significantly more secure attachment and females had significantly more fearful attachment. Of the fearfully attached, 60% fulfilled the criteria for PTSD after exposure, compared to 19% of the securely attached. Fearfully attached adolescents also showed an increased exposure to direct and indirect events. Linear regression analysis showed that gender, fearful attachment style and six of the traumatic events and negative life events (serious accidents, suicide attempt, abortion, bullying, absence of a parent, and suicide attempt) explained 41% of the variation in traumatization. Conclusion: A fearful attachment style was associated with female gender, increased exposure and traumatization.

Lifetime Exposure to Traumatic Events and Post Traumatic Stress Symptoms in Iranian High School Students

Ahmad Ghanizadeh, MD; Maryam Tavassoli, MD

Objective. To study the prevalence of life events and predictor of Mississippi scale (MS) score, trauma experience, and PTSD symptoms in students.

Method. Seven hundred thirty five high school students were selected by stratified cluster sampling. They completed the self-report trauma checklist, The Mississippi Scale for Civilians (CMS) (Keane et al, 1998) which is a 39 self-report items questionnaire derived from the Diagnostic and Statistical Manual of Mental Disorders III-R criteria for PTSD, and Life Events Questionnaire— Adolescent version (LEQ—A) (ALE) (it measures non-PTSD negative and positive events in the last 12 months (Masten et al 1994).

Results. About 99% of the subjects were exposed to at least one of the traumas listed. Gender, individual total number of experienced traumatic events, and ALE in last year predicted MS score. About 27.7% of the sample scored more than the cutoff point in MS.

Conclusion. There are extremely high rates of trauma in an adolescent community population. It is similar to the rates reported in adults with serious mental illness in Western countries. Most of them were exposed to "witness or being in a bad car accident", which is different from rates in other studies. ALE is severe as traumatic events in predicting MS score.

Involving People who Lived Experience of Dissociative Disorders in Professional Training and Education

Kathryn Livingston; M. Goodwin

The UK national survivor-led association for dissociative survivors and their allies First Person Plural is evolving its training activities in parallel with a mainstream general mental health environment, which is identifying good practice and encouraging service-user involvement in the education and training of the workforce. Such “involvement has the capacity to enrich the learning of students, offering a more stimulating and challenging learning experience – and one which can equip students to practice more effectively” (Tew et al, 2004). Our trainers are ‘real experts’ (Gold, 2004), i.e., those with lived experience of dissociative disorders. Since, in the UK, most education, training and practice in dissociation are outside the mainstream workers in this field do not routinely benefit from the general advances in the involvement of mental health service users. However, First Person Plural have developed collaborations with the UKSSD (ESTD-UK) training faculty and other professional organizations providing training in the field of dissociation and related areas, which has introduced service user involvement into the specialism. Trainees commonly evaluate the input by our trainers very positively, as do our collaborators. The presentation provides an opportunity to reflect on the benefits of involving service users/clients in the training of professionals about dissociation and to show how this has been achieved in the UK.

Learning objectives:

1. Outline the UK experience of the development of service user involvement in mental health services
2. Identify options for the involvement of service users/clients in the design and delivery of training and education of professionals in the field of dissociation
3. Identify what action individuals and their organizations can take towards increasing the influence of ‘real experts’ in the training and education of professionals

The Patient with a Learning Disability and Dissociative Identity Disorder

Valerie Sinason, PhD

Children and adults with a learning disability have little access to psychotherapy and are over represented in statistics on abuse prevalence (Sinason, 2002). Due to social stigmatization, which becomes internalized, attachment patterns are less likely to be secure. However, despite the increasing literature on trauma and disability, and particularly sexual trauma, dissociation is rarely mentioned (Johnson 2001) let alone dissociative disorder. The author provides a case study (with permission from the client and her family) of a young woman with Down's syndrome, whose systematic ritual torture from 6-16 within a respite care center for children and young people with a learning disability led to dissociative identity disorder, despite the love of her parents. The cognitive and emotional consequences of misdiagnosis in addition to D.I.D. are profound for a client with a learning disability. An outcome of the seven-year treatment to date is understanding of the abuse and how it led to dissociation, awareness of triggers and flashbacks and a corresponding lessening of self-injury and violent behavior.

Learning objectives:

1. The key psychoanalytic dynamics of learning disability and trauma
2. The impact of DID on someone with a learning disability
3. The importance of access to talking treatment for people with a disability

Creative and Concentration Meditation with DID Clients

Christine Forner, BSW, RSW

Meditation, mindfulness in particular, is proving to be a valid and effective treatment with many populations of clients. However, by those in the meditation and trauma fields, it is fairly common knowledge that mindfulness meditation techniques can be a painful experience for those with complex trauma and very difficult for those with dissociative disorders. To date there is little information and academic research on meditation as the major agent of change for clients with Dissociative Disorders, complex trauma and DID. Research provides evidence that DID and DDNOS clients may have a more highly imaginative component to their thinking processes than the regular population, therefore, therapeutic practices that primarily and deliberately involve the client's imagination is the foundation for these meditations. By developing meditation skills through creative, contemplative and concentration meditation techniques in the therapeutic setting, clients have demonstrated an ability to utilize and benefit from these skills. They become tools for strengthening affect tolerance, internal cooperation between fragmented parts and daily coping with life's demands. I will present my two clients case histories, some of the meditation processes used and the positive findings, all supported by research from the meditation fields and the field of trauma and dissociation.

Learning objectives

1. Define psychotherapeutic meditation and its benefits
2. Discuss why creative meditation is beneficial with this population by emphasizing the use of imagination
3. Discuss the process and outcomes found with two case studies

Relationship Trauma: Grounded Theory Investigation of Women's Traumatically Abusive Intimate Relationships

Tricia Orzeck, PhD

Objective: Intimate relationship abuse creates debilitating, sometimes traumatic, effects to the recipient's physical, psychological, emotional and spiritual well-being. Previous qualitative research has not generated a theory about trauma and abuse in intimate relationships nor have the salient constructs for criteria in new trauma diagnoses been confirmed. The present study examined the experiences of adult women in traumatically abusive relationships.

Method: Grounded theory methodology is an inductive process with limited interpretation for discovering new theories rooted in the data (Glaser & Strauss, 1967). An integrated theoretical formulation representative of relational forms of trauma was generated using these rigorous methodological procedures. Eleven abused women participated.

Results: The women's experiences encompassed a pervasive pushing-pulling dynamic, accompanied by increasingly intense emotional reactions and varied coping responses, including initial anger and shock, avoidance symptoms, and self-dysfunctional symptoms. Further, the traumatic relationship progressed through a series of stages: the Beginning of the Relationship, the Initial Abusive Behaviors Stage, the Perceptual Shift Stage, the Trauma Stage, and the Moving On Stage.

Conclusions: These findings vary from previous conceptualizations of posttraumatic processes and symptomatology (APA, 1994; Herman, 1992; Walker, 1989; 1994; Vandervoort & Rokach, 2004). The present study did not find all DSM-IV criteria essential. The women progressed through different stages than previously proposed by Walker and they were not in a state of pervasive fear and helplessness. The pulling component in the present theory was partially explained by Dutton and Painter's traumatic bonding but not the pushing component, which weakened the bond when the relationship trauma progressed.

Personal Characteristics Affecting Psychological Stability of Battle-ried Military Personnel (Combatants)

Elena Isaeva, PhD; A. Degtyarev MA; George Rhoades, PhD

Objective: Need for participating in “hot places” missions where members of police have to function similar to soldiers, is a significant psychological load. Stress steadiness is an important characteristic that determines capacity for work of members of special purpose police group (SPPG), their stability and balance in civil life. This research is dedicated to determine factors that influence psychological stability of members of SPPG to extreme circumstances and following adaptation to professional and social life.

Methods: Subject: 59 members of special-purpose policemen who were commissioned to Chechen Republic on July-September 2004. Average age $28 \pm 4,9$.

Instruments: prospective observation, “Accentuation of person”(Leonhard-Schmichek, 1992), “WCCL” (Lazarus, 1988), “LSI” (Plutchik, 1979) were used.

Results: Factors that influence psychological stress stability were:

- 1) Age: the younger (less than 26) the lower stress stability.
 - 2) Number of missions correlates with high stress stability.
 - 3) Hyperthymic character in combination with pattern of emotivity supply with plasticity and flexibility of emotional reactions. That was typical for the most stress stable members.
 - 4) Positive correlations between stress stability and mechanism of defense “negation” were revealed. Moreover, actualization of unintentional mechanism “negation” in extreme situations ensures capability for active problem-focused copings (systematic problem solution) use. Capacity for obstacle negotiation, ability for independent decisions taking in non-typical circumstances was noted mostly in members with high-grade stress stability.
- Conclusion: Our investigation revealed that emotional response style and psychological defense, operations participating experience and skills of effective self-control increase the threshold of psychological stress stability and prevent PTSD development.

Worrying about trauma: Is this linked to re-offending risk?

Vittoria Ardino, PhD; Paola Di Blasio, PhD; Luca Milani, PhD

Objective: Perpetrators of violence may have histories of early victimization and present PTSD symptoms. Thus this study explores associations between childhood traumatization, PTSD, and re-offending risk in offenders. It is hypothesized that worry – a dysfunctional cognitive strategy – may maintain offending behavior by mediating the effect of PTSD symptoms upon re-offending risk.

Method: A sample of 80 prisoners (30 females; mean of age: 44.36; 50 males: 34.7) was assessed for reported early victimization, PTSD according to the DSM-IV-R, and worry by the Penn State Worry Questionnaire. Re-offending risk – the likelihood of recommitting a crime in future – was measured by IORNS (The Inventory of Offender Risk, Needs and Strengths).

Results: Of this sample, 40% reported emotional neglect, 36% lack of care, 28% maternal physical abuse, 26,7% paternal physical abuse, and 14.7% sexual abuse. 72% of the sample had PTSD symptoms and 30.7% were at risk of re-offending. Reported early victimization was correlated with re-offending risk ($r=0.23$; $p<0.01$). PTSD scores were higher in those with higher levels of worry. A mediation-moderation model of regression showed that worry mediated PTSD and re-offending ($R^2=0.371$; $p<0.01$).

Conclusions: The prevalence of PTSD among offenders was higher than that in the general population, as has been reported elsewhere. Treatment of worry and PTSD may reduce re-offending risk.

Posttraumatic Stress Regressive Syndrome (PSRS) in Russian Juvenile Prisoners.
Radik Masagutov, MD

Background: Russian juvenile prisoners can be characterized as a "caste-structured" population; that is, they are informally stratified along a peer social hierarchy, which is tolerated within the system. A notable minority of juvenile prisoners are chronic victims of physical violence, sexual assault, torture, and threats of violence.

Method: Clinical Case Study: this paper reports 85 juvenile cases of all 623 imprisoned Russian male adolescents from 14 to 18 years old (13.6%), who were under psychiatric examination in 1998-2000 in two Russian juvenile jails. These jails were located in Sterlitamac city, the Republic of Bashkortostan.

Results: These 85 juveniles were victims of physical and/or sexual violence, or torture. They expressed a similar constellation of psychiatric symptoms suggestive of PSRS: (1) psychic and behavioral regression symptoms (loss of neatness, loss of normal human speech, loss of fastidiousness, and eating food waste); (2) bulimia; (3) some PTSD symptoms, and (4) depression. Genesis of this psychiatric constellation is discussed as an example of dissociative thinking. Etiologic factors, predisposing factors, and factors that influence the clinical picture of this disorder are discussed.

Conclusion: The authors describe a regression syndrome that should be considered as an additional form of traumatic stress mental disorder, specified in an adolescent prison population. Its clinical description seems suitable to a heading ICD-10 "Reaction to severe stress, and adjustment disorders" (F43).

Shame, Guilt and PTSD in a Sample of Childhood Sexual Abuse Victims

Alon Blum, MA; Ask Elklit, MSc.

Background: Shame and guilt are self-conscious emotions evoked by self-evaluation and self-reflection. When experienced excessively and inappropriately they are destructive to the self. The nature of shame often prevents victims from seeking help, and can disrupt treatment when victims avoid disclosing particularly problematic aspects of the experience.

Objectives: Due to the lack in studies of shame and guilt after CSA, the current study: 1) examined the relationships between shame, guilt, and psychopathology among victims of incest. 2) Examined the relationship between shame, guilt, and twenty different acts of sexual abuse.

Methods: At an outpatient clinic, 69 consecutive patients filled out a battery of questionnaires, including measures of PTSD, shame, and guilt. Thirty subjects responded at a six-month follow up study.

Results: Significant positive correlations between shame guilt and PTSD at both times were found ($.47 < r < .9$; $p < .005$). Three specific acts of sexual abuse positively correlated with shame and guilt (r values between $.27$ and $.46$; $p < .05$).

Conclusions: The data supports the importance of shame and guilt to psychopathology after CSA. The nature of the specific acts of sexual abuse which were found to correlate with shame and guilt suggests that when a relationship between victim and perpetrator is characterized by a false sense of intimacy, resulting psychopathology can be more complex than following a well defined assault.

Borderline Psychosis, Double Binds and Chronic Relational Trauma in Borderline Personality Disorder

Ruth Blizard, PhD

The essence of BPD is the instability of relationships, self-image and affect, accompanied by transient dissociative or psychotic-like symptoms. Trauma-based dissociative processes may underlie many of the symptoms of BPD, including the apparently psychotic symptoms. More important, dissociation based in double binds and chronic relational trauma may account for the instability of identity, affect, behavior and relationships. Acute, episodic impairment in reality testing may result from dissociative symptoms such as illusions, disorientation and flashbacks. A more pervasive and essential form of impairment of reality testing seen in BPD is based on partially or fully dissociated, polarized perceptions of self and others. Dissociated, i.e. split, mental representations of the good and bad aspects of the self in relationship to caregiver cannot be integrated into whole self and object representations, impairing the ability to interpret people's appearance, intentions and behavior. Attachment relationships with caregivers who are dissociative, psychotic or sociopathic involve thousands of frightening, double-binding interactions that may impair the development of reality testing in a more pervasive and insidious manner than discrete traumatic events. Case examples will illustrate treatment of persons with BPD, pervasive instability, impaired reality testing, and delusions of grandeur and persecution.

Learning objectives:

1. Identify the role of double binds and chronic relational trauma in the genesis of dissociated self-states.
2. Show how attachment to dissociative, psychotic or sociopathic caregivers may lead to impaired reality testing.
3. Illustrate treatment of pervasive instability through the therapist's acting as a relational bridge.

EMDR and EMDR Adaptations in the Treatment of Dissociative Disorders

Joanne H. Twombly, MSW

This workshop offers ways to incorporate Eye Movement Desensitization and Reprocessing in the treatment of clients with Dissociative Identity Disorder, Dissociative Disorder Not Otherwise Specified and ego state work. Used carefully, EMDR and EMDR adaptations can accelerate the treatment process. A liability is that its incorrect use can accelerate decompensation in clients with complex trauma and attachment disordered histories. This workshop offers suggested uses of EMDR and EMDR adaptations to facilitate stabilization, orientation to the present, decrease some negative transferences and to provide a protective format for processing traumatic material.

Learning objectives:

1. Participant is able to identify stages of treatment of dissociative disordered clients where EMDR and EMDR adaptations can be used.
2. Participant is able to use EMDR adaptations to orient dissociated parts of the mind to present time.
3. Participant has knowledge of how to develop a controlled process of using EMDR for trauma processing.

Diagnosis and Treatment of Dissociative Disorders in a Transcultural Context

Marjolein van Duijl, MD

Background. Dissociation is a worldwide phenomena present in many cultures. Disputed in the literature are the etiology (relationship with traumatic experiences), contextual and cultural influences on the presentation and management (such as possessive trance states), and the boundaries between normal and pathological dissociation and the differential diagnosis. Increasingly, also in western countries, with growing numbers of refugees and immigrants, clinicians come across patients with dissociative symptoms. Current western psychiatric diagnostic categories and treatment models seem limited in dealing effectively with dissociative presentations in a transcultural setting. Aim. More insight in diagnosis and management of dissociative disorders in the transcultural practice. Method: A participatory workshop in which the applicability of the current (experimental) diagnostic criteria in the DSM IV, (also for dissociative and possessive trance disorders) will be discussed and practiced. Case histories from the African and Dutch clinical setting with traumatized refugees will be used to illustrate different idioms of distress, explanatory models and culturally sensitive interventions. Presenters' research findings on the relation between spirit possession, dissociation, and trauma in Uganda will be referred to, as well as existing literature.

Learning objectives:

1. To acquire skills in recognizing and classifying dissociative disorders in the transcultural practice.
2. To achieve insight in explanatory models and possibilities on intervention strategies.
3. To support a cultural sensitive attitude in the approach of trauma and dissociation.

Shame and Dissociation: Utilizing Tompkins' Innate Affect Theory and Nathanson's Compass of Shame in the Treatment of DID and DDNOS

Richard P. Kluff, MD

For many traumatized individuals the shame family of emotions (e.g., embarrassment, shame, humiliation, mortification) plays an important role in their experience of traumatization, their self-appraisal in the aftermath of traumatization, their interpersonal behavior, and their difficulties in accepting and benefiting from psychotherapy. In this workshop, shame will be explored from the perspective of Donald Nathanson's exposition of the seminal work of Sylan Tompkins. The affect of shame will be discussed, along with the development of shame scripts for its management. The four classes of shame scripts will be described, and the cognitive aspects of the shame response explained. Scripts will be shown to resemble ego states, and to often become characteristics of particular alters in dissociative disorder patients' alter systems. Psychotherapies that address shame-related concerns early in treatment often reduce resistance effectively. Furthermore, since much that dissociative disorder patients withhold is in the conscious awareness of alters, and is kept out of the treatment due to shame-related concerns, shame reduction often results in patients rapidly sharing memories without requiring extensive and intrusive exploratory interventions.

Learning objectives:

1. List the four points on Nathanson's Compass of Shame
2. List five of the cognitive distortions typically associated with the experience of shame
3. Define the term "script" as it is used in innate affect theory.

Somatoform Dissociation

Chair: Ellert Nijenhuis, PhD

According to DSM-IV, mental dissociation is manifested in disturbances of memory, consciousness, identity, and altered perception of the environment, i.e., psychoform dissociation. However, an increasing number of clinical observations and empirical studies of the general population and clinical samples consistently suggest that dissociation is manifested also in bodily phenomena such as anesthesia, analgesia, motor disturbances, and pain, i.e., somatoform dissociation. Several retrospective studies have found that somatoform dissociation is correlated with exposure to potentially traumatizing events. This symposium presents a longitudinal study which demonstrates that exposure to trauma may be an important causal factor of somatoform dissociation. An other contribution will make the case for reclassification of DSM-IV conversion disorders as somatoform dissociative disorders, reuniting these disorders and the other dissociative disorders in one singular category, that in the 19th century was known as hysteria.

Conceptual, Empirical and Classificatory Issues

Ellert Nijenhuis, PhD

According to DSM-IV, mental dissociation manifests in disturbances of memory, consciousness, identity, and altered perception of the environment, i.e., psychoform dissociation. However, clinical observations of more than 120 years, ICD-10, and an increasing number of empirical studies suggest that dissociation also manifests in bodily phenomena, such as anesthesia, analgesia, motor disturbances, and pain, i.e., somatoform dissociation. This presentation reviews the evidence for somatoform dissociation, its associations with traumatization, and with trauma-related disorders ranging from posttraumatic stress disorder to dissociative identity disorder. Studies support the theoretical model that major somatoform dissociative symptoms relate to animal defense-like reactions to threat to the integrity of the body and threat to life. Somatoform dissociation, historically subsumed within the “hysteria” concept alongside psychoform dissociative phenomena such as dissociative amnesia and dissociative identity disorder, has been classified as somatoform disorders since DSM-III. Since then, there have been repeated calls to re-classify conversion disorder with the dissociative disorders, as in ICD-10. Although reintegrating conversion disorder with the dissociative disorders is not bereft of complications, there is a strong empirical and theoretical case for such a re-classification.

Somatoform Dissociation and Traumatic Experiences in the General Population

Päivi Maaranen, MD; Antti Tanskanen, MD; Heimo Viinamäki, MD

Objective: The relationship between somatoform dissociation and traumatic experience was examined in a general population sample.

Methods: The sample comprised 1596 participants aged 25-64 years. The study questionnaires included the Somatoform Dissociation Questionnaire (SDQ-20), questions about traumatic experiences (wartime experience, natural disaster, life-threatening accident, victim of violent crime, domestic violence and childhood sexual abuse), and sociodemographic variables.

Results: There were 61 subjects with a SDQ-20 score of 30 or more (3.8%). Among them the mean SDQ-20 score was 37.3 (SD 8.6), and 21.9 (SD 4.3) among all participants. The prevalence of wartime experience was 2.9%, natural disaster 2.2%, life-threatening accident 8.4%, being a victim of violent crime 16.4%, domestic violence 17.1%, and childhood sexual abuse 4.5% among the whole sample. 11.4% had experienced two or more traumatic experiences. Odds ratios, adjusted for significant covariates, were obtained from multiple logistic regression analysis that estimated the likelihood of high somatoform dissociation in different trauma categories. Of the six trauma variables childhood sexual abuse (AOR 2.7 [95% CI 1.2-6.8], $p=0.016$), and being a victim of violent crime (AOR 2.1 [95% CI 1.0-4.2], $p=0.049$) were associated with high somatoform dissociation. The risk of high somatoform dissociation was increased with two or more traumatic experiences over two-fold (AOR 2.4 [95% CI 1.3-4.5], $p=0.004$).

Conclusions: Traumatic experiences are common in the general population. Both single and multiple traumatic experiences had statistically significant associations with high somatoform dissociation.

Somatoform Dissociation in Medically Traumatized Children: A Norwegian Longitudinal Follow-up Study

Trond Diseth, MD

Objective: Prospective studies on child abuse and child development are constrained by ethical considerations making it impossible to examine the causal impact and courses of early, severe and chronic adverse childhood experiences. However, the use of “experiments of nature”, e.g. medically traumatized children, allows us to study these effects.

Method: Chronic somatic illnesses often involve invasive medical treatment procedures that can have a traumatic impact on child development. To explore possible consequences of medical treatment procedures, three groups of children with congenital anomalies were examined longitudinally into adulthood for mental health and dissociative experiences; including the Adolescent Dissociative Experiences Scale (A-DES), the Dissociative Experiences Scale (DES) and the Somatoform Dissociative Questionnaire (SDQ-20).

Results: Anal dilatation, an invasive medical treatment procedure performed daily by the parents the first four years, was correlated with the frequency and severity of persisting dissociative symptomatology. The procedure was the only significant predictor of A-DES and SDQ-20 scores, and one of two significant predictors of DES scores.

Conclusions: This “experiment of nature” has permitted a specific and unique opportunity to examine the impact of early traumatic exposure on child development in the absence of parental malevolence, and on later dissociative outcome in adolescence and adulthood. The findings might be valuable theoretically to our understanding of the development of psychopathology and the persistent of mental and somatic health problems into adulthood, and may lend itself for comparison with data on sexually abused children.

Somatoform Dissociation and Comorbidity in Turkish Clinical and Community Samples

Vedat Şar, MD

One of the diagnostic categories related to somatoform dissociation, conversion disorder is extremely prevalent in Turkey (Sar, in press). Although they may occur repetitively, conversion symptoms are usually transient and the clinical condition may end up with an other diagnostic category; e.g. an anxiety or mood disorder. Moreover, there is usually extensive psychiatric comorbidity in cross-sectional evaluation. Among patients with conversion disorder, a concurrent DSM-IV dissociative disorder is a powerful predictor of high psychiatric comorbidity, childhood trauma reports, and a history of suicide attempt or self-mutilation (Sar et al., 2004). A comparison with conversion disorder in terms of symptomatology, childhood trauma history and psychiatric comorbidity suggests that somatization disorder is a rather severe form of the same psychopathology (Sar et al, in press). Somatoform dissociation may be a useful concept in representing this spectrum of psychopathology. However, it needs to be adjusted to medical model and current diagnostic classification systems which are based rather on objective signs and underline differential diagnosis from other psychiatric and medical disorders in particular.

The Impact of Early Life Stresses on Attachment and Self-regulating Systems: Long-term Imprints?

Chair: Eric Vermetten, MD, PhD, co-chair: Ruth Lanius PhD

Discussant: Bessel van der Kolk MD

There is now ample evidence from the preclinical and clinical fields that exposure to early psychological trauma has both dramatic and long-lasting effects on neurobiological systems and functions. This is especially so when it occurs at critical ages or developmental transitions, and when it involves disruption in fundamental attachment relationships. This places survivors at risk in adolescence not only for PTSD but also for psychiatric, medical and psychosocial morbidity and impairment. This symposium will address this topic by presenting empirical studies that focus on the aftermath and biology of these long-term imprints.

The impact of Traumatic Holocaust Experiences Across Three Generations: Attachment and Stress Regulation

Marinus H. van IJzendoorn, PhD; Mirjam J. Bakermans-Kranenburg, PhD

What are the long-term effects of persecution on the child survivors of the Nazi Holocaust, now living in Israel? Born several years before or during the Second World War, they survived the persecution with neglect, separations, and losses during their early, most formative years. From earliest age on, they witnessed their parents' helplessness in providing basic protection and safety. Many of these children survived by being separated from their parents, and by being put in the care of strangers. Children who had become orphans depended on the kindness of strangers and sometimes suffered custody arrangements not chosen for their best interests. All were confronted with the disasters the Holocaust brought upon their family and wider social network. They had to readjust to even more separations and ever changing circumstances when being moved from country to country, before immigrating into Israel, to establish a new family life and to become parents and grandparents. Keilson (1992) coined the concept of 'sequential traumatization' to describe the impact of the Holocaust experience and its aftermath. In this presentation, we provide an overview of our empirical and meta-analytic work on Holocaust traumatization and its impact on the first, second, and third generation, with emphasis on vulnerabilities as well as resiliencies of the survivors. The research on the Holocaust is presented as a case study of long-term consequences of early traumatization, as well as the lack of intergenerational transmission of trauma.

Child Maltreatment and Socio-Economic Risks in the Development of Disorganized Attachments

Marjan J. Bakermans-Kranenburg, PhD; Marinus H. van IJzendoorn, PhD; C. Cyr; E. Euser

Recently a nationwide study on the prevalence of child abuse and neglect (CAN) was conducted. For the first time, an educated guess about the prevalence of maltreatment in the Netherlands was made, using more than 1100 sentinels. The prevalence was estimated to be 107,200 cases in the year 2005, which amounts to 30 cases of maltreatment per 1,000 children in the age range of 0-17. The risk for CAN was highly elevated in families with very low educated parents (almost 7-fold increase). When both parents were jobless the risk was more than 5 times larger. In a series of meta-analyses the differential impact of maltreatment and various socioeconomic risks on attachment insecurity and disorganization was examined. More than fifty studies were traced with more than 4000 children who came from non-maltreating high-risk backgrounds or were documented to (additionally) have suffered from maltreatment. We tested whether proportions of insecure and disorganized attachments varied as a function of risks. Results showed that children living under high-risk conditions (including maltreatment studies) were more likely to show insecure or disorganized attachments than children living in low-risk families. Large effects sizes were found for maltreatment: Maltreated children showed more insecure or disorganized attachments than other high-risk children. However, children exposed to at least 5-6 socioeconomic risks were as likely as maltreated children to become disorganized. Overall, meta-analyses show the traumatizing impact of maltreatment for attachment disorganization as well as attachment insecurity, and they also suggest that the cumulative impact of socioeconomic risks may be similar

Attachment Representations in Dutch Military Veterans: Is Secure Attachment a Protective Factor in the Development of PTSD?

Dorith Harari, MD; Marinus H. van IJzendoorn, PhD; Mirjam J. Bakermans-Kranenburg, PhD; H.G.M. Westenberg, MD; Eric Vermetten, MD, PhD

Is there a correlation between PTSD symptomatology and is secure attachment a protective factor in the development of PTSD? Attachment disorganization in the Adult Attachment Interview (AAI) is indicative of lack of resolution of a loss or a trauma. Although it shows a limited phenomenological overlap with diagnostic criteria of PTSD, unresolved trauma may be at the core of posttraumatic stress. It should therefore be expected to correlate with PTSD symptomatology. Security of attachment is implied as a protective factor in the development of psychopathology in general. In clinical samples, secure attachment is less represented than in general population. As secure attachment is central to stress regulating capacity, it is expected to be a protective factor in the development of PTSD. In this study, the Adult Attachment Interview was administered to 62 Dutch military veterans, 32 of whom were admitted for treatment of PTSD after deployment in UN peace keeping missions. Thirty controls were matched for age, year and country of deployment. Severity of PTSD symptoms was assessed with the Clinician Administered PTSD Scale. Attachment disorganization score (U) based on lack of resolution of trauma was found to highly correlate with total CAPS score and to highly predict patient or control status. Secure attachment, using the three way classification, was found equally prevalent in the PTSD group as in the control group. It can be concluded that the correlation between attachment disorganization and presence and severity of PTSD is a further validation of the AAI. A protective effect of secure attachment in the development of PTSD seems to be lacking.

Altered Self-Perception and Early Life Psychotrauma: A Compromised Default Network

Ruth Lanius, MD; R. Bluhm; P.C. Williamson; E. Osuch; T. Stevens

Can long-term effects of early trauma be found in the brain? Recent neuroimaging work in healthy subjects has shown the existence of a 'default brain network' of correlated brain regions active during rest. These regions, which include discrete brain regions as the posterior cingulate, anterior cingulate and medial prefrontal cortex, and lateral parietal areas, have also been implicated in self-reflection. This study investigated whether (1) there are abnormalities in the default network in early trauma related PTSD patients and (2) the extent of these abnormalities correlates with clinical measures of alexithymia, self perception and dissociation. Resting state fMRI scans were obtained from 17 patients with PTSD due to early childhood trauma and 17 healthy controls. Connectivity between the posterior cingulate and other brain areas was assessed. In healthy controls, activity in the posterior cingulate seed region was found to positively correlate with other regions of the default network. This correlation was reduced or absent in the PTSD group. Connectivity of the posterior cingulate with regions of the default network was modulated in the PTSD group by score on the Toronto Alexithymia Scale and on the Dissociative Experiences Scale. These results suggest that the integrity of this 'default network' is compromised in early trauma related PTSD and that the extent of the deficit reflects clinical measures of altered self perception.

An Inpatient Treatment Model for Severely Traumatized and Dissociative Children Arianne Struik, MA; Sander van Arum, MD; Marcel Schmeets, MD

The treatment of severely traumatized children is often complicated by attachment problems to their parents, who often are also survivors of chronic childhood trauma. The child's trauma frequently activates unresolved parental trauma. Such complications can interfere with the parent's ability to maintain an adequate parental position and to support the child's treatment. Unpredictable, intense emotional parental reactions can exacerbate the child's attachment difficulties, thus creating an ongoing process of interpersonal conflict, frustration and fear. The Phase Treatment (in Dutch: 'Fasenbehandeling') is an inpatient child treatment program accompanied by outpatient treatment for the parents. The physical separation between the child and the parent fosters a stabilization of their relationship. Through trauma focused therapies and training programs the children receive an opportunity to change their attachment strategies and behaviors. The parents are provided with an opportunity to process their own unresolved trauma. The newly learned skills are integrated in systemic therapy where both parents and children are encouraged to practice new ways of interaction. Preliminary results from the Fasenbehandeling show that approximately 70% of the children returned to live with their families. The combination of the integrated treatment addressing trauma and attachment issues for both child and parent seem to be the promising ingredients of this comprehensive approach.

Learning objectives:

1. Understand the entanglement of the attachment of children, their trauma's and unresolved parental trauma.
2. Learn the basic tenets of the inpatient child treatment program accompanied by outpatient treatment for the parents (The Phase Treatment).
3. Gain an understanding of which families can or cannot benefit from this integrated treatment, through case presentations and questions.

Trauma Scene Investigation (T.S.I.): Investigating and Structuring the Chaos in Families of Severely Traumatized and Dissociative Children

Anke van Schooten, MA; Arianne Struik, MA

Most of what we know about the diagnosis and the treatment of traumatized children starts at the point where the circumstances of the traumatizing events are relatively clear. The complicated process of investigation and structuring the chaotic circumstances in families of severely traumatized children is unfamiliar to most therapists. This case presentation illuminates the pre-therapy phase and involves two young children abused by a family member. The siblings seemed to have been sexually involved with each other and were suspected to abuse other children. The mother, a severely traumatized woman diagnosed with a borderline personality and a victim spousal physical abuse, has been unavailable because she was hospitalized following a suicide attempt. The alcoholic father, a former convict, was suspected to threaten the children not to talk to us. When confronted, he threatened to retaliate. The question in such situations is: what should be done and in what order? How can one disentangle such chaos? Victims and perpetrators are often members of the same family, strongly and loyally connected to each other, thus creating insoluble conflicts for the investigated children. To address these complexities we propose the Trauma Scene Investigation (TSI) model as a template for the investigation and organization of the various aspects of the criminal trauma scene. The TSI model considers all possible actions for both child and parents (often, also the victim and the perpetrator) from a systemic standpoint. The model reduces collateral damage, saving resources that can be better used for stabilizing the victimized child and his or her parents.

Learning objectives:

1. Understand the range and quality of problems that need to be addressed in order to stabilize daily life for severe traumatized children
2. Learn the basic tenets of the Trauma Scene Investigation model and gain the ability to disentangle the chaos in these families.
3. Gain an understanding of which interventions to utilize under specific conditions, through case presentations and questions.

Transgenerational Trauma: Diagnosis and Treatment of Attachment Disorders

Karl Heinz Brisch, MD

Attachment disorders are a form of severe early psychopathology that emerges from early forms of violence of caregivers against the infant. Based on attachment theory a diagnostic classification system of attachment disorders is presented. The presentation of clinical case studies (with video) demonstrates the differential use of the classification system of attachment disorders in infants and childhood. This attachment-oriented diagnostic approach is compared with classification systems of other diagnostic manuals (ICD) and advantages and disadvantages are discussed. The general and special guidelines of attachment therapy are presented in the treatment of transgenerational trauma. The special treatment approach and the process of psychotherapy with various attachment disorders are demonstrated with audio-visual material.

Learning objectives:

1. To differentiate and to diagnose psychopathology and types of attachment disorders
2. To understand the process of transgeneration transmission of trauma
3. To define approaches of attachment-oriented treatment

Nonverbal Behavior in Traumatized Patient: Comparison between Childhood Onset versus Acutely Adult Onset Trauma

Anne Kirsch, PhD; R. Krause; S. Sachsse; J. Spang

Objective: In the present study we examined the facial affective behavior of acutely adult onset traumatized patients in comparison to childhood onset traumatized patients. Furthermore we analyzed as a moderator variables psychic complains, amnesia and derealization.

Methods: The facial affective behavior was coded with the Emotional Facial Acting Coding System, an instrument for the registration of facial movements with emotional relevance. The facial affective behavior of the patient's first and last EMDR session was videotaped and compared. The first 5 min of each session were coded by an independent rater (certified FACS user). The psychic complains were measured with the SCL-90-R (German version of Symptom Checklist-90-R), amnesia and derealization with the FDS (German version of the Dissociative Experiences Scale).

Results: Childhood onset and acutely adult onset traumatized patients showed the same reduction of overall facial activity. We found significantly higher psychic complains (global severity index) (SCL-90-R) in childhood onset traumatized patients and no difference in amnesia (FDS) between the two groups. Childhood onset traumatized patients showed higher values of derealization (FDS).

Conclusions: Acutely adult onset traumatized patients showed the same facial affective reduction as childhood onset traumatized patients in comparison to a healthy control group. Additionally childhood onset traumatized patients showed more psychic complains and derealization.

Alternative to Violence Organizational Policy to Prevent and Reduce the Risk of Secondary Traumatization

Judith van der Weele, MD

Alternative to Violence (ATV) is an NGO that works in the area of domestic violence. The therapists all work with clients both perpetrators and victims of domestic violence. Many have a child abuse history. Therapists are exposed to these stories, as well as exposed to ongoing violence and abuse issues. In all cases there is a strong focus on the child witness to abuse. Children living in danger are therefore a daily part of the reality of the therapists. Issues of risk assessment and lack of system support in these cases may well be the case. Therefore, the organization considers all therapists to be at risk for secondary traumatization and is obligated to implement a policy of prevention, care and risk reduction. This work will be contrasted with how therapist care is organized within the mental health care system. The regional trauma center RVTS develops training modules for the mental health care in eastern Norway. Here there is little to no systematic debriefing or care of therapists in systems overloaded with work. The beginning initiatives of change in this work will be described and contrasted to the challenges in the NGO. We will share the ATV policy document on secondary trauma prevention at the conference. Individual and systems levels of intervention: (1) yearly employee feedback sessions include the topic; (2) the organization reports to the board on the topic; (3) all take part in group debriefing four times a year; (4) extra free time, varied workload; (5) individual debriefing when needed. This can be initiated by the leader or therapist; (6) developing a culture of care; (7) all therapists are expected to teach others and consult and deliver debriefing services when necessary.

Learning objectives:

1. Describe organizational policy.
2. Increase awareness of therapist needs.
3. Describe useful organizational solutions.

When Trauma Therapists Dissociate: A New Approach to Secondary Traumatization

Judith Daniels, PhD

Objectives: Dissociation is widely viewed as a survival mechanism that is triggered in life-threatening situations. Dissociation is also known to be the best predictor for the development of PTSD. As Secondary Traumatization (ST) has been shown to consist of similar symptoms as PTSD, the question arises if dissociation could bring on those symptoms in a non-life-threatening situation such as the therapeutic setting.

Methods: An online-study was conducted with a sample of German-speaking therapists ($n=1.124$). Secondary traumatization was measured with a German questionnaire (FST, $\alpha=.94$). Peritraumatic dissociation was evaluated with a set of items derived from scientific literature (PD, $\alpha=.79$).

Results: The two instruments correlate with Kendall-Tau-b = .390 ($p < .000$). PD scores predicted FST scores in a hierarchical regression analysis with $R^2=.29$. The comparison of a high and a low dissociation group established by a median-split depending on the PD scores yielded significant results: FST scores are higher in the high dissociation group than in the low dissociation group ($p < .000$).

Conclusions: Dissociative coping presents an important risk factor for the development of Secondary Traumatization in therapists. Idiosyncratic peritraumatic processing of client's trauma material predicts secondary traumatization better than work setting, work experience or education. Specialized supervision is advised. Active coping strategies like imaginative distancing techniques might lead to similar emotional detachment, but do not appear to be predictive of ST. The individual tendency to retreat to automatic, and therefore uncontrolled, dissociation should be monitored to assess the risk of developing ST.

Diagnostic Drawing Series for Dissociative Adolescents: A Prospective Study
Serge Goffinet, MD; N. Quevy, Psychotherapist

Art making gives people with dissociative disorders the opportunity to share their traumatic experiences without talking; symbolism allows them to reveal information in a drawing while simultaneously camouflaging it from the viewer. The aim of the study was to examine if the adolescent's pattern is similar to the adult's pattern. Participants: 107 patients enrolled; all were inpatients in a Crisis Unit between 12 and 21. 46 complete protocols were analyzed. Method : clinical diagnosis was established by a multiclinicians consensus. Questionnaires of dissociation assessment were DIS-Q (Dissociation-Questionnaire), ADES-II (Adolescent Dissociative Experience Scale) and AMID (Adolescent multidimensional Inventory for Dissociation). The Diagnostic Drawing Series (DDS) was authored by BM Cohen (and B Lesowitz) in 1981; the DDS combines a multi-drawing tasks, with the systematic study of the art productions. DDS includes semi-opened questions about the drawings. Results : in the DDS, we found many similarities between the current study and both Cohen s and the Dutch Study. Great differences were noted : poor abstraction, no disintegration and less usage of the space of the page. We discuss the possibility to use the DDS as a projective test (a diagnostic tool); we also reported how the adolescents experienced the research. More patients are needed to validate our preliminary results (this is an ongoing study).

Learning objectives:

1. Present the interest of Diagnostic Drawing Series (DDS)
2. Illustrate DDS for adolescents: first step in art therapy
3. Discuss DDS as a projective test

Validation of the Post-Traumatic Stress Disorder Checklist Scale (PCLS) in French and its Use in Cognitive-Behavioral Group Therapy

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Objectives and Methods: A brief self-report instrument for the evaluation of the symptoms of Post-Traumatic Stress Disorder (PTSD) could be useful as a screening tool in a primary care setting and serve as a measure of progress in therapy. The PTSD Checklist Scale (PCLS) is a 17-item self-questionnaire based on the 17 PTSD symptoms appearing in the DSM-IV. It is composed of three subscales, one for each syndrome: Re-experiencing, Avoidance and Numbing, and Physiological Hyperarousal, and thus a global score for PTSD and three subscale scores can be obtained in order to assess the presence of PTSD symptomatology.

The objectives of this study are to validate the French version of the PCLS among 113 psychiatric patients and 31 non-clinical subjects and to demonstrate the utility of the instrument during the course of group and individual Cognitive-Behavioural Therapy (CBT) for depression and psychological trauma (childhood abuse, traumatic death of a loved one).

Results: Subjects with PTSD as diagnosed by a clinical interview tend to have significantly higher PCLS global and subscale scores compared to those without the disorder. The cutoff score for PTSD diagnosis is 44. Other psychometric properties (concurrent validity, test-retest reliability and factor analysis) are satisfactory.

Changes in PCLS scores mirror improvement in psychiatric symptomatology and social functioning obtained over the course of therapeutic intervention.

Conclusions: The French version of the PCLS is a valid self-report instrument for PTSD, and it can be useful as a screening tool as well as a measure of improvement in therapy.

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