**October 25th, 10:30 SESSION I ROOM 1 Panel ID PN-04**

## What is the relation between psychological trauma and dissociation?

**Andreas Laddis,** Andreas Laddis is a psychiatrist in Massachusetts, USA. He has worked mainly in public institutions for psychiatric care, where he promoted psychotherapy for clients with complex posttraumatic disorders. In the International Society for the Study of Trauma and Dissociation, he has advocated for the development of testable theory as the necessary means for clinical experimentation and shareable progress. He is currently Editor for Frontiers in the Psychotherapy of Trauma and Dissociation, ISSTD's new clinical e-journal., Shrewsbury, US

**Ellert R.S. Nijenhuis,** Ph.D., is a psychologist, psychotherapist, and researcher. He has engaged in the diagnosis and treatment of severely traumatized patients for more than three decades, and teaches and writes extensively on the themes of trauma-related dissociation and dissociative disorders. He initiated and continues to be engaged in the biopsychological study of complex dissociative disorders. Nijenhuis is a consultant at Clienia Littenheid, Switzerland, and collaborates with several European universities. His theoretical, scientific, and clinical publications include the book Somatoform Dissociation. With Onno van der Hart and Kathy Steele he co-authored the book The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization. The first two volumes of Nijenhuis' recent trilogy The Trinity of Trauma: Ignorance, Fragility, and Control appeared in 2015. The third volume, Enactive Trauma Treatment was released in 2017. The International Society for the Study of Trauma and Dissociation granted him several awards, including the Lifetime Achievement Award.

**Jenny Ann Rydberg** is a clinical psychologist (MA from the Université Libre de Bruxelles) in private practice specializing in the treatment of complex trauma and dissociation, an associate teacher at the University of Lorraine, a member of the editorial committees of the European Journal of Trauma and Dissociation and the Journal of EMDR Practice and Research.

**Adriano Schimmenti,** PhD, DClinPsych, is full professor of psychodynamic psychotherapy and director of the MSc Clinical Postgraduate Degree at UKE – Kore University of Enna (Italy), where he is also the Delegate of the Rector for students with neurodevelopmental, physical and Learning disabilities. He is deputy director of the SIPDC – Italian Society of Psychological Assessment, research director of the IIPP – Italian Institute of Psychoanalytic Psychotherapy, and is the Editor of an Italian book series on psychotraumatology. He has been trained in the administration and scoring of several interview-based measures, including the Adult Attachment Interview, the Attachment Style Interview, the Childhood Experience of Care and Abuse, and the Psychopathy Checklist-Revised. He has authored/coauthored 102 articles, 34 book chapters, and 8 books. He has published in leading journals on the topics of childhood trauma, attachment, and dissociation.

As the name of ESTD (or of ISSTD) implies, we infer a causal relation between a) traumatic stress and b) dissociation in the individual's course of mental activity and initiatives in a social and material life world. We, on this panel, stipulate that the two phenomena co-occur. Replicable empirical evidence for the theory we share requires us to gradually, collaboratively narrow down what characterizes "true" trauma and dissociation. It requires us to discern a) what distinguishes traumatic stress from ordinary stress and b) what distinguishes trauma-related dissociation from phenomena that merely resemble it. As experts, we owe it

to ourselves and to traumatized individuals to collaborate for progress with the boundaries of what we include in those two concepts. The panelists will each present their version of that endeavor. Then, they will open it to questions and statements from the audience.

**October 25th, 10:30 SESSION I ROOM 2 Symposium ID SM-06**

## From screening to diagnosis of complex dissociative disorder

*This symposium focuses on practical issues and challenges associated with recognizing dissociative disorders and coming up with a valid diagnosis. Presentations relate to the diagnostic process and elaborate on screening and specialized, in-depth assessment. Potential traps and diagnostic errors are also mentioned and illustrated with a case study.*

***Screening online for dissociative disorders with E-psyche***
**Igor J. Pietkiewicz**, PhD, *Psychotherapist and supervisor, Head of the Research Centre for Trauma & Dissociation, ESTD Board member*
*Research Centre for Trauma & Dissociation, SWPS University of Social Sciences and Humanities, Poland*
**Radosław Tomalski**, MD, PhD, *Psychiatrist, psychotherapist and supervisor*

*Research Centre for Trauma & Dissociation, SWPS University of Social Sciences and Humanities, Poland*
*It is typical of trauma survivors to avoid talking about traumatic experiences and their consequences. Dissociative patients will not spontaneously report many of their symptoms, unless healthcare providers directly ask about them. For this reason, it is helpful in general practice to use instruments inquiring about adverse childhood experiences, PTSD, and other dissociative symptoms. We will present an online application (E-psyche) offering easy way to administer screening tests, monitor results, and share feedback. During a consultation, clinicians can qualitatively analyse test outcomes and consider further specialised evaluation, if they suspect a dissociative disorder. Because administrating structured clinical interviews is time-consuming, these initial steps are helpful to assess the risk of a dissociative disorder.*

***Why Trauma and Dissociative Symptoms Interview (TADS-I)?***
**Suzette Boon**, PhD, Clinical psychotherapist in private practice

Dissociative symptoms and disorders are not easy to recognize for the following reasons: (1) There is no consensus about the concept of dissociation. (2) Patients generally do not present with dissociative symptoms but have a tendency to hide or avoid there symptoms. (3) There is a lot of overlap in symptoms with other disorders, such as: personality disorders and Complex PTSD. (4) Clinicians do not receive systematic education in diagnosis and treatment of dissociative disorders.(5) There is an ongoing polarized debate about the existence of dissociative identity disorder (DID) as a reliable and valid diagnosis.
TADS-I was developed to enable a trained clinician to make a DSM-5 or ICD-10 diagnosis of dissociative disorders thus including somatoform dissociative disorders. A section of trauma-related symptoms is added to get a more complete clinical picture including symptoms of PTSD and Complex PTSD. Finally, it helps the clinician better distinguish between genuine and false positive DID patients. In this presentation I will discuss

difficulties in diagnosing dissociative disorders and show small video vignettes to illustrate diagnostic complexities.

***I am like an empty jar, experiencing emotions of the part which logs in - a case study of a patient with false positive DID***

**Igor J. Pietkiewicz**, PhD, *Psychotherapist and supervisor, Head of the Research Centre for Trauma & Dissociation, ESTD Board member*
*Research Centre for Trauma & Dissociation, SWPS University of Social Sciences and Humanities, Poland*
**Radosław Tomalski**, MD, PhD, *Psychiatrist, psychotherapist and supervisor*
*Research Centre for Trauma & Dissociation, SWPS University of Social Sciences and Humanities, Poland*
**Anna Bańbura**, M.Sc. *Psychologists, PhD Candidate*
*Research Centre for Trauma & Dissociation, SWPS University of Social Sciences and Humanities, Poland*
**Suzette Boon**, PhD, Clinical psychotherapist in private practice

*Psychiatric manuals, ICD-10 and DSM-5, outline selected phenomena characteristic of dissociative identity disorder but do not provide specific guidelines to qualitatively distinguish the dissociative and non-dissociative nature of some symptoms. During specialised assessment, clinicians should go beyond the face value and carefully examine various clusters of symptoms, how patients experience or talk about them. This lowers the risk of false-positive DID diagnosis of patients with other disorders.*
*During this presentation we will discuss a patient with borderline personality disorder who was previously diagnosed with DID. This 'unseen child' embraced new diagnosis as a metaphor explaining her intra-psychic conflicts and allowing her to feel special. Searching information about DID using Internet and literature helped her elaborate her symptoms, which she presented during clinical interview to show a switch between dissociative parts. A short part of video recording will illustrate that.*
*Using the Trauma & Dissociative Symptoms Interview allowed to rule out significant clusters of dissociative symptoms, especially: PTSD, amnesia, and the existence of autonomous dissociative parts. On the other hand, we observed personality diffusion, problems with self-esteem and affect regulation, anxiety, persistent difficulties in interpersonal relationships, and conflicts with expressing difficult emotions. Data collected during the interview confirmed borderline personality disorder and ruled out dissociative identity disorder, despite the patient presented the symptoms by the book. We stress that the clinical evaluation of complex dissociative disorders requires special training and skills.*

**October 25th, 13:15 SESSION II ROOM 1 Symposium ID SM-10**

## Trauma and psychological consequences in heterosexual and LGB population

*Adverse childhood experiences (ACEs) represent a source of early stress conditions that can lead to the development of post-traumatic stress consequences. In our symposium we present data on an Italian heterosexual and LGB sample and we analyze the relationship between sexual orientation, ACEs and their long-term consequences related to trauma.*

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**Co-authors:**
**Filippo Perrini**, PsyD, Istituto A.T. Beck of Rome, Italy
**Roberta Rubbino**, PsyD, Istituto A.T. Beck of Rome, Italy
**Roberta Borzì**, PsyD, Istituto A.T. Beck of Rome, Italy
**Gemma Battagliese**, Phd, Centro Alcologico della Regione Lazio (CRARL), Department of Clinical Medicine, Sapienza University of Rome, Italy

*Adverse Childhood Experiences (ACEs) refer to some of the most intensive and frequently occurring sources of stress that children may suffer early in life (WHO 2019, statement). LGB people represent a population with a high prevalence of ACEs due also to homophobia and gender non conformity.*
*The aim of the talk is to examine prevalence of childhood abuse, neglect and household dysfunctions among LGB and heterosexual adults. Participants were 1184 heterosexual and LGB subjects recruited informally in locations where they could respond with a complete anonymity. Adverse childhood experiences were assessed with the ACE questionnaire. Data showed higher prevalence of ACEs in LGB population. In particular, lesbian and bisexual women are more exposed to sexual abuse; bisexual men are more physically maltreated; gay men are more witnessing their mother been abused. Clinical implications will be discussed.*

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**Antonella Montano**, PsyD, Istituto A.T. Beck of Rome, Italy

*Gender nonconformity is higher in same-sex sexual oriented people and has been associated with lower quality of life, mental and physical health (Gordon, 2017). Some studies indicate that gender nonconformity represents a risk factor for traumatic experiences and lifetime probable posttraumatic stress disorder (Roberts, 2012). In the present study we examined the relationship between gender nonconformity and adverse childhood experiences among heterosexual, lesbian, gay, and bisexual (LGB) individuals. Participants were 1184 heterosexual and LGB individuals who completed the Adverse Childhood Experiences (ACEs) questionnaire and the Traditional Masculinity and Femininity (TMF) scale. We found that higher gender nonconformity is associated with higher prevalence of adverse childhood experiences as emotional and*

*sexual abuse and emotional and physical neglect. Gender nonconformity is greater also in people exposed to parental separation or divorce and household mental illness. Future studies will investigate gender nonconformity as a vulnerability factor predicting the higher probability to be exposed to traumatic experiences in LGB population.*

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*LGB population has a greater exposure to adverse childhood experiences (ACEs) and early adversities are associated with leading causes of adult psychopathology. For these reasons, LGB clients more frequently need for treatment. So, we examined the relationship between ACEs, psychological consequences and prevalence of treatment request in sexual minority and heterosexual adults. Participants were 1184 italian subjects that completed the Symptoms Checklist-90 (SCL-90) and ACE (Adverse Childhood Experiences) questionnaire. In spite of a higher prevalence of ACEs and of psychopathological symptoms in LGB subjects, no significant differences in the treatment request were revealed among heterosexual and LGB people. Results and some issues will be discussed. Clinical implications suggest that mental health professionals should recognize that their own attitudes and knowledge about the experiences of sexual minorities are relevant to the therapeutic process with these clients.*

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**Antonella Montano**, PsyD, Istituto A.T. Beck of Rome, Italy

*Personality Disorders (PDs) are psychopathological conditions resulting from the interaction between temperament and environmental factors. Research suggests that individuals with PDs report a higher number of negative or traumatic events during their childhood (Johnson et al., 2005). Traumatic and invalidating experiences are extensively studied in Borderline Personality Disorder (for a review see Crowell, 2009, 2016) but studies also suggest an important role of early negative experiences in all PDs. In the present study we examined the relationship between temperament, adverse childhood experiences and Personality Disorders. Participants were patients with a PDs diagnosis who completed SCID-5 interview, the Adverse Childhood Experiences (ACEs) questionnaire and the Temperament and Character Inventory-Revised (TCI-R). Significant associations between temperament, adverse childhood experiences and PDs were found. Results and clinical implications will be discussed.*

**October 25th, 13:15 SESSION II ROOM 2 Symposium ID SM-05**

## Principles and interventions from Sensorimotor Psychotherapy to treat clients with complex trauma, chronic shame and dissociation

*Building on the implementation of Sensorimotor Psychotherapy's foundational principles in their practice, therapists will learn to help clients identify and strengthen their somatic resources through mindful experiments in the treatment of trauma. We will also illustrate the clinical application of the principles and interventions of Sensorimotor Psychotherapy to the treatment of shame-related issues.*

***Embodying The Founding Principles Of Sensorimotor Psychotherapy***
**Jenny Ann Rydberg,** Psychologist, University of Lorraine, Buis-les-Baronnies, France

*Sensorimotor psychotherapy's founding principles were first defined by Ron Kurtz, the originator of Hakomi therapy. These principles are: unity, mindfulness, non-violence, organicity, and mind-body-spirit holism. They guide and inform practice, from moment to moment in session, on the level of case conceptualisation and treatment planning, and in the therapist's beliefs and outlook on mental health and the therapeutic relationship.*
*Briefly, unity reflects to our interconnectedness and commonalities; mindfulness is used as a particular way of paying attention, with curiosity, but without judgment; non-violence involves being sensitive to the patient's boundaries, needs, and pace, being careful not impose the therapist's own agenda; organicity refers to the patient's inherent and organic wisdom and ability to heal; mind-body-spirit holism recognises that the mind and the body, the emotional, cognitive, and somatic, are inseparable.*
*The presentation will illustrate the implications and effects on therapy for each of these five principles, so that the participants may leave with practical ideas that may be applied within their usual frameworks and techniques in order to foster a sense of safety, attunement, collaboration and reparative attachment experiences.*

***Somatic Resources In Sensorimotor Psychotherapy***
**Nedjma Mohammedi,** Clinical psychologist

*Somatic resources play an important in each of the 3 phases of the treatment of trauma, described by Pierre Janet. In Phase 1, the development of resources helps to stabilise the patient. In Phase 2, they provide the necessary support to deal with and integrate traumatic memories. In Phase 3, they consolidate the skills and creativity that are needed to manage life events.*
*Somatic resources (such as alignment, grounding, etc.) are central in sensorimotor psychotherapy. The therapist teaches the patient to track and read the body during the entire session. Reading the body enables the assessment of body defensive responses that were not implemented or completed at the time of the traumatising event, such as flight or fight. Based on these observations, the therapist invites the patient to try out physical experiments in mindfulness, by mobilising the body's core or periphery, to initiate or to complete the body's defensive sequence. This enables the patient to activate existing somatic resources, and to identify and install somatic resources that were missing.*

*In this presentation, participants will learn how to set up a physical experiment to access the patient's somatic resources.*

***Treating Shame With Sensorimotor Psychotherapy Interventions***
**Raphaël Gazon,** Psychologist, Sensorimotor Psychotherapy Institute Trainer

*Shame is an overwhelming affect associated with intense autonomic nervous system activation, inability to think clearly, incapacity to behave voluntarily and impulse to hide or flee. It functions as a defensive strategy against interpersonal or social danger. In many ways, the very particular body posture and autonomic pattern of shame are fairly similar to what we observe in trauma. In particular, the issue of shame and self-blame is central to chronic and developmental trauma.*
*This presentation will illustrate the use of Sensorimotor Psychotherapy interventions that directly address the manifestations of shame in movement, posture, and gesture of the body, as well as in a dysregulated nervous system.*
*With an emphasis on the relational nature of shame, special attention will be given to the importance of the therapeutic relationship. Typically, when we try to create closeness with someone who experiences shame, it activates more shame. Therefore, when a therapist tries to move a client out of shame, it often forces the client back into that shame.*
*In this presentation, we'll review how therapists can use the foundational principles of Sensorimotor Psychotherapy to create a relational context that maximizes the possibility of breaking out of the relational vicious circle of shame.*

**October 25th, 16:15 SESSION III ROOM 1 Symposium ID SM-04**

## Legacy of Complex Trauma

*This symposium features 1) an assessment specialist who outlines traumas that were missed by inadequate family court processes, 2) an 'Expert-by-Experience' who explores bio-energetic aspects of trauma and survivor artwork and, 3) a clinical psychologist who discusses treatment of victims of extreme abuse who have done harm to other victims.*

***The Legacy of Satanist Ritual Abuse (SRA) Trauma & Mind Control: A C-PTSD Assessment Case Study***
***Background***
**Rainer Hermann Kurz,** C. Psychologist, Outstanding Achievements, London, Long Ditton, United Kingdom

*A UK Family Court ruling deprived a young mother of custody for her toddler as four Court Appointed Experts had concluded that she had been 'delusional' about witnessing a sexual assault on her boy and (implicitly) about delivering a baby as a young teenager that succeeded from incestuous rape and 'disappeared'.*
*Method*
*Observation of a session run by a Clinical Psychologist raised concerns as somatoform dissociations were ignored and two key index incidents not covered. Following a series of six privately funded and video-recorded disclosure sessions a C-PTSD assessment session was conducted.*

*Results*
*The mother within 10 minutes rattled off 67 events of which about 2/3 had been disclosed previously. The most frequently mentioned traumas were categorised as Threat (7), Sadism (5), Physical Abuse (5) and Satanism (5) including instances of 'drinking blood' and 'eating improper food'. Furthermore, two instanced of Bestiality were mentioned. Three violent deaths and two disappearances of new-born babies were mentioned. Family Persecution was mentioned three times and Authority Persecution once.*
*Conclusions*
*A 100-page report incorporating evidence from 5 suitably qualified mental health professionals was compiled and an appeal application signed by the mother. Shortly afterwards she abandoned the appeals process under coercive pressure.*

***Seeing Invisible Wounds - A Bio-energetic Understanding of Systematic Trauma***
**Declan Howard,** Investigator, Outstanding Achievements, London

*Background*
*Trauma victims report wounds and problems which are to a greater or lesser degree invisible. In treatment it is very helpful to locate these wounds and diagnose them in type, cause and effect. These wounds are located in the energy body. The energy body is in many contexts synonymous with the consciousness.*
*Method*
*This presentation aims to familiarise the participants with a bio-energetic model which serves to interpret*
*1. The relationship between energy body wounding and the emotional, nervous, muscular and hormonal systems.*
*2. Subsequent alterations in cognition, behaviour and also development.*
*3. The motivation and methods of organised predation.*
*This will be illustrated using survivor artwork which demonstrates these processes, lesions and consequences as portrayed by the damaged person.*
*Results*
*A bio-energetic locus of wounding clarifies the trauma model. It explains why traumatic events have short-term and long-term consequences, and indicates specific psychosomatic mechanisms for symptom generation through consciousness-body-environment feedback processes. It is also applicable to multiple relevant fields including law enforcement, criminology, poetry and literature, psychotherapy, psychopathology, self-care and metaphysics.*
*Conclusions*
*To demonstrate that invisible does not mean non-existent, and how the accurate perception and description of invisible wounding can be used in healing.*

***Treatment of Victims Who Condemn Themselves for Harm Done to Other Victims***
**Rainer Hermann Kurz,** C. Psychologist, Outstanding Achievements, London
**Ellen Lachter,** Clinical Psychologist and Registered Play Therapist and Supervisor in private practice
**Declan Howard,** Investigator, Outstanding Achievements, London

*Background*
*This presentation will discuss the treatment of victims who have done harm to other victims driven by: a) abuser coercion and threats, b) psychological manipulation by dissociation-savvy abusers, and, c) enactments of sexual and physical abuse in dissociated states.*
*Method*
*Treatment of victims of extreme abuse with dissociative disorders for 25 years revealed that many of these victims were subjected to torture to coerce them to harm other victims.*
*Results*
*The presentation will cover:*
*1. Abuser tactics to coerce perpetration*
*2. Dissociative "breaks" in agency and forms of dissociated self-states formed in victims in response*
*3. Dissociation-savvy manipulation of victims to induce new self-states to form and to manipulate and fear-condition self-states ("programming") for long-term control to serve abuser agendas, including harm to others*
*4. Abuse enactments of dissociated abuse that cause harm to others*
*5. Uncontrolled eruptions of rage*
*6. Treatment strategies to help victims develop self-compassion in the place of self-condemnation and to gain mastery over abuse enactments*
*7. Coerced and/or dissociated perpetration vs. conscious and willing perpetration*
*Conclusions*
*Victims of extreme abuse have had no choice but to discover the capacity for cruelty and violence resides in them as well as in their abusers. See:*
*<http://endritualabuse.org/coerced-under-torture/>*

**October 25th, 16:15 SESSION III ROOM 2 Symposium ID SM-09**

## TRE as a body-mind therapy working with traumatic consequences of physical and mental illness

*In this symposium, we will focus on how TRE can be used to address trauma, dissociation and attachment ability of people being severely influenced by physical or mental illness. TRE is being applied for breast cancer survivors, people with multiple sclerosis, and deprived young adults.*

***Using TRE (tension and trauma releasing exercises) with people with multiple sclerosis (MS) in The Danish Multiple Sclerosis Society***
**Michael Nissen,** Clinical psychologist, The Danish Multiple Sclerosis Society, Valby, Denmark

*Background: Many people, suffering from a disease or not, have problems with self-regulation. In this context, self-regulation means the person's ability to regulate the level of physical and emotional tension. Not being able to self-regulate often results in chronic tension patterns, emotional problems, stress reactions, and inadequate lifestyles. The process of being diagnosed with, and thereafter living with, a chronic disease like MS can lead to shock, trauma and crisis. In this situation, the person suffering from a chronic disease is dependent on having a good ability to self-regulate.*

*Methods: In The Danish Multiple Sclerosis Society we have for the last 12 years offered TRE to around 800 people with MS (PwMS). TRE activates the ability for self-regulation through the body´s tremor mechanism. Results: The results with TRE with PwMS is based on anecdotal case histories and a pilot study. The most significant results: decrease of tension, fatigue, stress, depression, anxiety and dissociation and improvement of body sensation, attachment and owning one's body. Discussion: Many PwMS have been traumatized through their hospital treatment and as MS is a central nervous system disease their nervous system has come out of balance. TRE helps the central nervous system getting more in balance.*

***Hidden motion – working with deprived young adults in TRE and dance art***

**Kirsi Törmi,** Clinical Gestalt Psychotherapist, Postdoctoral researcher University of Arts, CERADA (The Center for Educational Research and Academic Development in the Arts)

*Trauma-informed and trauma-sensitive practices of therapy have taken an increasing role in therapy and counseling during the last ten years. As we know, the impact of living through traumatic events and in a traumatic relationship can result in a range of behavioral health problems other than PTSD, including anxiety problems, depression, substance abuse and psychosis. According to statistics these problems are increasingly growing in Finland especially among young adults. However, in Finland trauma-informed practice in social services is playing a very tiny role, if any.*
*The purpose of this research is to study how to increase social engagement through the body movement that takes into account the autonomic nervous system. In the presentation, I will describe my ongoing research (February 2019 – October 2019 ) in Social services (in six cities) with deprived young adults.*
*I have created group-practice called "Hidden motion" where I combine TRE (Tension, Stress and Trauma Releasing Exercises) and a method "Move your feelings, feel your movements" from my doctoral dissertation. Research tries to formulate a bodily working method that can be utilized in social work in the future. Hypothesis of this research is that bodily and trauma-sensitive way of working is valuable when supporting clients' agency and empowerment.*

***TRE for breast cancer survivors***

**Tjasa Stepisnik Perdih,** Psychotherapist, Assistant Professor, School of Advanced Social Studies, Department of Psychosocial Counseling

*Breast cancer (BC) is one of the most common cancers affecting women worldwide. Research has emphasized that for many, cancer may be experienced as trauma and may lead to traumatic stress symptomatology. In the first year after BC treatment, the majority of women exhibit high levels of distress, appearance and body image concerns, and psychological dysfunction. In some women, issues such as a threat to life and body integrity including disfigurement, disability, pain, and loss of social and occupational roles persist. Moreover, persistent emotional distress can lead to psychological pathology, including anxiety disorders or clinical depression. For that reason, in Slovenia, Europa Donna offers psychosocial support for BC survivors. Support includes TRE, a body-mind therapy which has been applied to specifically address stress responses and the relationship with the body which was affected by the treatment. TRE works based on the body´s natural tremor mechanism and thus represents a unique intervention for autonomic recovery from stress. In this symposium, we address the implications of TRE to a group of 8 BC survivors. The improvements in pain symptomatology, sleep disturbances, body image, stress coping mechanism following the 8-week TRE intervention are discussed.*

**October 26th, 10:30 SESSION IV ROOM 1 Panel ID PN-02**

## Maladaptive Daydreaming: An Overview of a Proposed Disorder

**Colin Ross,** Psychiatrist, The Colin A. Ross Institute for Psychological Trauma, Richardson, TX USA, Richardson, United States
**Eli Somer,** clinical psychologist, University of Haifa, School of Social Work, Haifa, Israel
**Adriano Schimmenti,** Professor of Psychopathology, Faculty of Human and Social Sciences, UKE – Kore University of Enna, Italy
**Alexandra Sandor,** PhD student, University of Debrecen, Faculty of Public Health, Institute of Behavioural Sciences, Debrecen, Hungary
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**Naomi Halpern**, CQSW, Director, The Delphi Centre, Melbourne, Australia

This panel discussion about maladaptive daydreaming (MD) will include presenters from Israel, Italy, Hungary, Poland and the United States. People with MD spend many hours per day in a complex inner world that often includes many different characters and complex plots and actions. The MD causes significant distress and dysfunction. Presenters will discuss the diagnostic criteria for MD, its phenomenology, comorbidity and associated features. The differential diagnosis includes addictions, OCD, dissociative disorders and stereotypical movement disorders. None of these features are present in all cases. One presentation will focus on the artwork produced by 9 individuals in treatment for MD. Another panelist will present a correlation network analysis of 135 cases of MD. Another presenter will discuss the relationships between MD and fantasy proneness, default mode networks and other models that might help us understand MD. Trauma and dissociation are prominent in MD, but do not occur in

all cases. Nevertheless, even if typical structural dissociation is not present, virtually all individuals with MD describe a dissociation between their empty, unhappy, drab external self and life and their comparatively rich, colored and fulfilling inner fantasy world. MD should be understood and considered by clinicians treating trauma and dissociation.

**October 26th, 10:30 SESSION IV ROOM 2 Symposium ID SM-08**

## Symposium: TF-SET: Trauma Focused Social Emotional Therapy. A phase oriented treatment 3.0

*A new treatment model for intensive group-based treatment already applied to over 300 clients with complex PTSD and complex Dissociative Disorders is presented. After its theoretical framework is outlined, the organisational and therapeutic aspects will be presented from therapist and client perspective. The first treatment results will be discussed.*

***The theoretical framework of Trauma Focused - Social Emotional Therapy (TF-SET)***
**Tom Horemans,** Psychiatrist, Managing director, Top Referent Trauma Centre, Eindhoven Mental health care, the Netherlands, Eindhoven, The Netherlands

*First of all the polyvagal theory (S. Porgess) will be explained as a base to provide a language to develop a new phase-oriented treatment model that focuses on safety, development, autonomy and connection. Several action systems for survival and their neurobiological origin are illustrated as well as the way they interfere with daily life of early childhood trauma survivors.*
*Next, the Window of Tolerance (A. Schore, P. Ogden) and the Trauma Triangle (according to the S. Karpman Drama Triangle) as theoretical frameworks to contain and transform emerging re-enactments in the therapeutic process will be explained.*
*The therapy, developed as a result of the above theoretical frameworks, is trauma focused and trauma informed. It is called TF-SET: Trauma focused social emotional therapy. The main aim of this therapy is to improve social emotional development. By participating in group based treatment in a trauma sensitive environment, clients are able to develop social emotionally in a relatively secure attachment environment that serves as playground for daily life interactions.*
*Experts by experience are part of the therapist team to increase the containment that is needed to provide a secure environment.*

***The organisational and therapeutic aspects of TF-SET***
**Linda Gerits,** Clinical Psychologist, Managing director Top Referent Trauma Centre, Eindhoven Mental health care, the Netherlands

*The second presenter will outline the organisational and therapeutic aspects of this new intensive group-based treatment for patients with complex PTSD and complex Dissociative Disorders from therapist and client perspective. Autonomy, connection and development is facilitated in a community-based Therapeutic Community that focuses on the intensive use of different groups and e-health. Firstly, the focus is on the*

*trauma sensitive social emotional environment the Therapeutic Community has developed in the last 6 years. Secondly, the focus is on the various aspects of the multidisciplinary treatment program and the way clients are involved through individual psychotherapy and a combination of peer groups, skill training and e-health. Next, the implications for therapists as a new generation of phase-oriented therapists in this multidisciplinary treatment model will be discussed. Benefits and challenges therapist experience in their work as a part of the Therapeutic Community, as well as the window of tolerance and Trauma Triangle and their practical implications for therapists will be illustrated. From a therapist view, the therapeutic process, treatment outcome, social emotional development and daily life effects for clients will be discussed.*

***Client perspective of TF-SET***

**Tom Horemans,** Psychiatrist, Managing director, Top Referent Trauma Centre, Eindhoven Mental health care, the Netherlands
**Co-authors:**
**Linda Gerits**, Clinical Psychologist, Managing director Top Referent Trauma Centre, Eindhoven Mental health care, the Netherlands

*In a video presentation, several client participants of the Therapeutic Community will provide the audience with their input. They focus on client participation in the Therapeutic Community and the various peer groups. The clients in the video illustrate what they have achieved, how they have experienced the therapeutic process and what this process means for their own social emotional development and daily life. From the client perspective, they focus on the way working with the Window of Tolerance and Trauma Triangle has been part of their growth and development and what benefits and challenges they have met.*

**Linda Gerits,** Clinical Psychologist, Managing director Top Referent Trauma Centre, Eindhoven Mental health care, the Netherlands
**Co-authors:**
**Tom Horemans**, Psychiatrist, Managing director, Top Referent Trauma Centre, Eindhoven Mental health care, the Netherlands

*The first research data of TF-SET and directions for future development.*
*The present state of affairs after developing a Therapeutic Community for 6 years and 300 participants so far will be addressed. Future developments and directions for research will be mentioned.*

**October 26th, 13:15 SESSION V ROOM 1 Symposium ID SM-07**

## Depersonalisation and derealisation in different groups

*This symposium focuses on symptoms of depersonalisation and derealisation in patients representing dissociative and non-dissociative disorders. Presentations elaborate on different qualities of these alterations in consciousness, their triggers and consequences.*

***Depersonalization in healthy people - theoretical models***
**Igor J. Pietkiewicz**, PhD, *Psychotherapist and supervisor, Head of the Research Centre for Trauma & Dissociation, ESTD Board member*
*Research Centre for Trauma & Dissociation, SWPS University of Social Sciences and Humanities, Poland*
**Roksana Duszkiewicz**, M.Sc. *Neurobiologist, PhD Candidate*
*Research Centre for Trauma & Dissociation, SWPS University of Social Sciences and Humanities, Poland*
**Radosław Tomalski**, MD, PhD, *Psychiatrist, psychotherapist and supervisor*

*Research Centre for Trauma & Dissociation, SWPS University of Social Sciences and Humanities, Poland*
*Depersonalization and derealization are alterations in consciousness which can normally be experienced by healthy individuals due to: significant threat, extreme exhaustion, use of certain substances or meditation techniques. It is estimated that 26-74% of healthy people have such experiences at least once during lifetime. In this presentation depersonalization and derealization will be discussed as natural reactions to certain circumstances and exemplified with case material. Modern theories explaining neural and psycho-physiological mechanisms behind depersonalization and derealization will be discussed to highlight differences between its healthy and pathological forms, observed in people with mental disorders.*

***Depersonalisation and derealisation in sexually abused women with complex dissociative disorders***
**Igor J. Pietkiewicz**, PhD, *Psychotherapist and supervisor, Head of the Research Centre for Trauma & Dissociation, ESTD Board member*
*Research Centre for Trauma & Dissociation, SWPS University of Social Sciences and Humanities, Poland*
**Radosław Tomalski**, MD, PhD, *Psychiatrist, psychotherapist and supervisor*
*Research Centre for Trauma & Dissociation, SWPS University of Social Sciences and Humanities, Poland*
**Anna Bańbura**, M.Sc. *Psychologist, PhD Candidate*
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**Mateusz Barłóg**, M.Sc. *Psychologist, PhD Candidate*
*Research Centre for Trauma & Dissociation, SWPS University of Social Sciences and Humanities, Poland*
**Szymon Nęcki**, M.Sc. *Psychologist, PhD Candidate*
*Research Centre for Trauma & Dissociation, SWPS University of Social Sciences and Humanities, Poland*
**Suzette Boon**, PhD, Clinical psychotherapist in private practice

*Depersonalisation and derealisation exist in different psychiatric disorders and are also common in non-clinical population, as reactions to physical exhaustion, using substances, or very stressful situations. However, empirical research exploring qualitative similarities and differences of these alterations in consciousness in clinical and non-clinical groups is limited in scope and number. In this presentation we elaborate on depersonalisation / derealisation in women who had been sexually abused and developed a complex dissociative disorder. Transcripts of in-depth interviews with them were subjected to interpretative phenomenological analysis. We present various aspects of depersonalisation and derealization, referring them to potentially different psycho-biological mechanisms.*

***Out-of-body experiences in women with Dissociative Identity Disorder, Personality Disorders and Psychosis***
**Igor J. Pietkiewicz**, PhD, *Psychotherapist and supervisor, Head of the Research Centre for Trauma & Dissociation, ESTD Board member*
*Research Centre for Trauma & Dissociation, SWPS University of Social Sciences and Humanities, Poland*

**Radosław Tomalski**, MD, PhD, *Psychiatrist, psychotherapist and supervisor*
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**Anna Bańbura**, M.Sc. *Psychologist, PhD Candidate*
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*Literature on somatognosia describes three types of autoscopic phenomena: autoscopic halucination (AH), heautoscopy (HAS), and out of body experience (OBE). AH involves seeing a clone of one's body, while the centre of consciousness remains in one's physical body. In HAS, people have difficulty to define, where their centre of consciousness is localised, they can switch between two different positions (physical and autoscopic) and this experience feels very real. In OBE, the centre of consciousness is located outside one's own body, which results in seeing oneself and the surroundings from the external perspective. OBE is generally considered an extreme form of depersonalisation and associated with complex dissociative disorders. However, we also found examples of these experiences in patients with other disorders. In this presentation we compare various features of OBE in patients with different diagnoses, discuss triggers, associated emotions, and reactions to that experience.*

**October 26th, 13:15 SESSION V ROOM 2 Symposium ID SM-02**

## Working with the procedural learning system: deeper brain functions and bottom-up processing

*Trauma effects concern embodied and procedural memories in subcortical systems of complex PTSD and dissociative disorders.*
*In this symposium authors will present their therapeutic approach and describe their attempt to positively influence the underlying neurophysiological processes involved in memory reconsolidation therapies and the procedural learning system related to relational mechanisms.*

***Deep Brain Reorienting for the treatment of Attachment Trauma***
**Remy Aquarone,** Pottergate Centre
**Frank Corrigan,** Trauma Psychotherapy Scotland

*This presentation focuses on a subcortical attachment system driving a tendency for approach or avoidance/defence which is hypothesised to be based in the brainstem orienting response to another person. The relevant neuroanatomy and functioning of the midbrain superior colliculi (SC), the adjacent periaqueductal gray (PAG), and the ascending monoamine systems from the brainstem activated by emotionally salient stimuli, especially those of a relational nature, will be outlined.*

*The implications for the body's holding of conflicted attachment tendencies, often made complex at a very early developmental stage when the cortex is not fully mature, will be discussed; these can explain some of the apparently contradictory aspects of dissociative and borderline presentations in adults.*
*The therapeutic, healing, reorienting which occurs is hypothesised to have its base in the midbrain but to generate transformation also through upper levels of the developed brain.*
*An audio-visual recording will be shown of a therapy session in which this method of Deep Brain Reorienting is used with an adult whose experience of severe early attachment trauma had clinical consequences throughout later life.*

***Self-Mirroring Therapy with Dissociative Identity Disorders (DID): a pilot project***
**Costanzo Frau,** Psychotherapy Service and Research on Trauma & Dissociation, Cagliari, Italy

*As many studies have shown trauma can interfere with the normal development of the brain causing a series of consequences both on a psychological and neurobiological level. This is why different therapies with dissociative patients focused their intervention on the physical aspects related to the trauma. Somatic psychotherapies, such as Sensorimotor Psychotherapy, incorporated mindfulness and attention to the experiences of the body into the therapy process, by paying attention to bottom-up aspects of psychophysiology (Ogden, Minton & Pain, 2006). Other treatments like Comprehensive Resource Model (Schwarz, Corrigan, Hull & Raju, 2016) and Deep Brain Reorienting (Corrigan, 2019) try to access to the implicit memory sequences based in the brainstem which influence feelings, thoughts and behaviours. In this research framework Self-Mirroring technique could contribute to improve the integration process with dissociative patients by working with the procedural learning system.*
*In my presentation I will describe a pilot project in which I tested Self-Mirroring Therapy with 5 Dissociative Identity Disorders (DID).*

***The therapy of the parts with patients with complex trauma and dissociation: relational strategies and emotional engagement between patient and therapist***
**Fabio AP Furlani,** CTC School of Cognitive Psychotherapy, Como, Italy

*The therapy of the parts with patients with complex trauma and dissociation: relational strategies and emotional engagement between patient and therapist.*
*We are living in a time when psychopathology seems to change faster than our methods to identify and understand it. Descriptive books - trying to stop the symptoms of mental disorders and allowing a conversation between clinicians, researchers and experts - risk to fail against time and to end up telling today something that yesterday was different already.*
*For every individual, the integrity of Self is the divide between a sensation of safety, balance and well-being versus restlessness, emotional dysregulation and ill-being. This translates into an open attitude versus a closed-off attitude in the relationships with others. Understanding the deep functionings with a constructivist approach allows a phenomenological analysis of dissociation seen as a sudden and clear interruption of sameness and selfhood, between continuity and discontinuity of Self.*
*In this scenario, while fully respecting the individuality of the patient, and in order to avoid a determinist drift, our treatment approach aims to shift from the judging aspects towards the Self and the world to an explorative curiosity of one's own ways to be and to suffer.*