Long term consequences of chronic traumatization: diagnosis and treatment inplications

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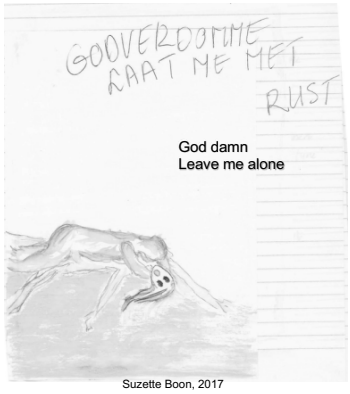
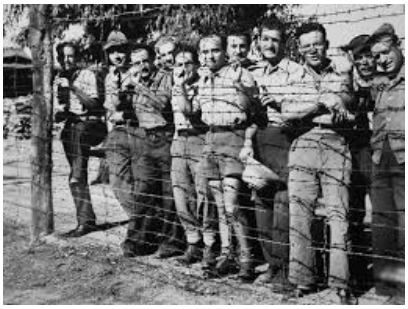
In my anguish, I cry out. The cry awakens me, and I emerge from the nightmare, exhausted.

Quote: Charlotte Delbo, survivor of Auschwitz

Type I and type II trauma

- Type I trauma: singular, once in a life time traumatizing event
- Type II trauma: *recurrent* traumatizing events usually starting in early childhood; physical and or sexual abuse, emotional neglect, being witness to violence, longterm war experiences, refugees, indoctrination and brainwashing in political prisoners





Nonrealization as the Core of Traumatization (Janet, 1935)

Trauma-related disorders primarily involve ***nonrealization***

- The person is unable to realize
  - Traumatizing events happened to "me"
  - Mental and behavioral actions belong to "me"
  - Events are over, i.e., the past is in the past
  - The "I" and "me" of then are part of the "I" and "me" of now

Charlotte Delbo

Novelist

Holocaust Survivor of Auschwitz

Nonrealization and Dissociation in a Survivor of Auschwitz

"I have the feeling that the 'self' who was in the camp isn't me, isn't the person who is here, opposite you. No, it's too unbelievable. And everything that happened to this other 'self,' the one from Auschwitz, doesn't touch me now, *me*, doesn't concern me, so distinct are deep memory and common memory."

Charlotte Delbo (1985, p. 13)

Nonrealization and Dissociation in a Survivor of Auschwitz

"Fortunately, in my anguish, I cry out. The cry awakens me, and I emerge from the nightmare, exhausted. It takes days for everything to return to normal, for memory to be "refilled" and for the skin of memory to mend itself. ***I become myself again, the one you know, who can speak to you of Auschwitz without showing any sign of distress or emotion."***

Charlotte Delbo (1985, p. 14)

Avoiding and Reexperiencing Traumatizing Events

Traumatized individuals alternate between episodes in which they experience the traumatizing event over and over again, as if it were happening here and now, and episodes in which they are relatively unaware of the traumatic experience and avoid reminders of it, on the surface undisturbed. This basic pattern of posttraumatic stress has been noted for the past hundred years.

Traumatic memory

-A traumatic memory differs from a persons autobiographical narrative memory because it is *partially* or *completely* dissociated

-Particially: certain components of the traumatic experience are dissociated [from ANP position (s)]

-Completely: all components of the traumatic experience are dissociated [from ANP position (s)]

In the Beginning:

Good Treatment
Begins
with
Good Assessment

Continuum of disorders specifically related to complex trauma (type 2 trauma)

- **Complex PTSD** related to type II trauma
- **Dissociative Disorders,** in particular:
  - Dissociative Identity Disorder (DID) type II trauma
  - Other Specified Dissociative Disorder (OSDD in DSM-5) (was DDNOS in DSM-IV)

Good treatment starts with Assessment

Diagnoses of Complex PTSD and Dissociative Disorders

Complex PTSD 2015 (Cloitre et all, 2013, 2014)

a complex PTSD class defined by **PTSD (has to meet PTSD criteria)** as well as disturbances in three domains of self-organization: **affective dysregulation, negative self-concept, and interpersonal problems**

Dissociative disorders

- Two most prevalent disorders are DID and Other Specified dissociatieve disorder.
- Both disorders are characterized by the fact that there is a division of the personality in dissociative parts.
- A distinction is made between parts with a functions in daily life and parts stuck in trauma- time

Spectrum of (pathological) dissociative symptoms

	Psychoform	Somatoform
Negative	Amnesia Depersonalization (out of body) Derealization (not recognizing friends, surrounding) "loss" of " talents" or capacities	'Conversion' symptoms : loss of hearing, vision, speech, smell, taste, strength in arms legs, paralysis Loss of sensation e.g feeling of pain, hunger, thurst , temperature etc) "I am just a head" (no connection with body)
Positive	Intrusions of dissociative parts Schneider's first rank symptoms	Pain, tics, onvrijwillige bewegingen Pseudo-epileptic seizures; Sensoric perceptions; somatic Intrusions(e.g feeling that legs are moving but it is not you who is moving

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Dissociative organization of personality

- Basically two types of dissociative personalities or dissociative "self states"

I. Part(s) functioning in daily life (one part of self in Complex PTSD and DDNOS)

II. Part(s) stuck in trauma time, keeping traumatic memories, feelings, bodily sensations

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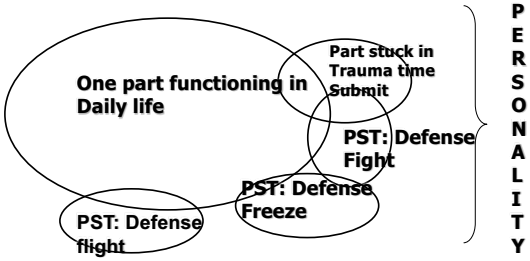
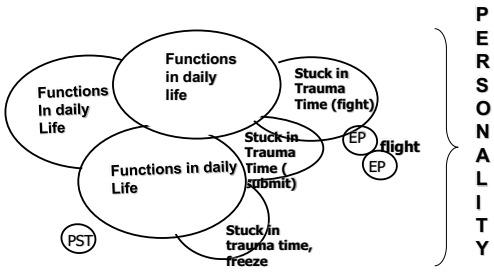
Other specified DD (subtype I, was DDNOS in DSM-IV) and some cases of CPTSD



adapted from Van der Hart, Nijenhuis & Steele (2001)

Boon, ESTD 2016

Dissociative identity disorder



Nijenhuis, Van der Hart, & Steele (2001)

Boon, ESTD 2016

But what is a dissociative part?

- **Therapist**

- There is a lot of confusion, especially when a therapist is not yet experienced in assessment and treatment of dissociative disorders, about dissociative parts. Sometimes borderline modes (Young, 2003) or ego states are confused with dissociative parts. It can also happen vice versa!

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Ego states, or dissociative parts?

- All dissociative parts are ego states but not all ego states are dissociative parts;
- Ego states retain a shared sense of belonging to the person as a whole
- Diss. parts have their own sense of identity, self-representation, autobiographical memory, and personal experiences (Kluft, 1988) (as opposed to ego states)
- Dissociative parts have a distinctive first person perspective, that is, a sense of "*I, me, and mine,*" (Van der Hart et al, 2006, Steele, Boon & van der Hart, 2017)

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Modes (Young, Klosko & Weishaar, 2003)

Schema Modes are a combination of activated schemas and coping styles into a temporary "way of being", a current emotional-cognitive-behavioral state

Young et al. (2003) described child modes (angry, impulsive,vulnerable and happy) dysfunctional parent modes (punitive and demanding), dysfunctional coping modes (surrender, avoidance and over compensation and healthy adult mode.

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Modes and dissociative parts

- Modes should be differentiated from dissociative parts in the same way as egostates:
- They contain, like ego states shared sense of belonging to the person as a whole
- They **do not have** their own sense of identity, self-representation, autobiographical memory, and personal experiences (see also Steele, Boon & van der Hart, 2017)

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Conclusion

- Modes and ego states should not be considered dissociative parts and should not be treated as if they are "separated parts"
- Some borderline patients rather conceptualize their modes or impulses as "dissociative parts" and claim amnesia or at least claim that they are not responsible for behaviors of these "parts". In those cases it is certainly not helpful to treat these modes as different "parts".

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Overlap of dissociative symptoms in complex PTSD and Dissociative disorders (DID and ASDD)

- There maybe amnesia and problems with concentration and memory
- Depersonalization and derealization
- Intrusions from traumatic material (this may also be intrusions from dissociative self states, voices)
- However, DID and ASDD are characterized by the presence of distinct dissociative personalities exprienced as "not me"; In CPTSD there maybe dissociative "emotional states" experienced as me

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When structured clinical assessment of CPTSD and dissociative pathology?

- In poly-symptomatic patients for example meeting borderline profile & (some) PTSD criteria (even without circumscribed trauma); hearing voices; mood and anxiety symptoms, conversion symptoms / pseudo-epileptic seizures; selfdestructiveness, dissociative problems (chronic depersonalization; memory loss, fugues)
- Cut-off scores DES above 25
- All patients who report severe and chronic (early) trauma histories
- Patients with many changing diagnoses who do not respond to treatment

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Type II trauma and it's long term consequences: more difficult to assess

Patients often do not present with their traumatic histories because:

- Patients often do not (want to) realize the relation between their trauma history and current complaints
- There may be a stong phobia for all affects related to the trauma histories
- Patients may even have amnesia for (part of) the trauma history
- Patients present with very different symptoms e.g mood, eating problems, sleeping problems, anxiety, alcohol drugs, somatic problems, relational problems, sexual problems etc

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Case of Nadja (1)

- 19 year old woman, refugee in Swedish psychiatry. Fled with father and younger sister from war-torn country.
- Main symptoms: passive, depressed, starving, nightmares and mood shifts from
- "Retarded" and inaccesible to unreasonable agressive outbreaks
- Varies in level of functioning, some days she goes to school, other days she can't get out of bed

Case of Nadja (2)

- Trauma history
  - Belonged to oppressed minority in home country persecuted for many years. Father had to give up shop. Masked men stormed the house several time. Nadja witnessed abuse of father and was raped 3 times herself while father couldn't intervene
  - Nadja grew up without mother who was alcohol and drugaddict. Mother disappeared when sister was born
  - Also emotional abuse and neglect from mother. Nadja did see mother sometimes before flight to Sweden
  - Upon arrival in Sweden she also worries about her mother (outbreak of viral disease among drug users in home country, she fears mother is dead.

Case of Nicole

- 26 year old woman, currently living (with her boyfriend) and working in Germany at a large agricultural farm
- Finished agricultural college several years ago
- Referred because of severe (pseudo) epileptic seizures; no neulogical symptoms/confirmation found
- Lost her first job (also in Germany) because of the seizures
- Trauma history of (severe) psysical abuse and witnessing violence among her parents; situations she has perceived as a child as life threatening

Case formulation: presenting problems

- (C)PTSD/ **dissociation**?
- Other (psychiatric) trauma-related symptoms
- Attachment problems
- Problems in the current family
- Existential problems
- Financial, social problems

Case formulation: (ego) strength and resources

- Every patient is different; differences in personality organization, ego capacities, support system, structure in daily life can influence the decision for a specific treatment program
- It is very important to know already existing resources and be aware of (ego) strenght of each patient

Case formulation: possible complications in the therapeutic relationship; risks for splitting

- How many previous therapists/treatments?
- Content of earlier treatment
- What were the reasons for termination?
- Inpatient treatment versus outpatient?
- Who terminated?
- Recurrent conflicts with therapists or treatment team(s)?/ severity of attachment problems
- Discussion of expectations of patient, possibilities of therapist
- Referral within clinic from other team : WHY???

Treatment plan based on:

- Severity and cluster of dissociative and (C PTSD) symptoms
- What type of dissociative organisation of self
- ***Severity of attachment problems / personality problems/organization***
- Other severe comorbidity that influence treatment options (e.g.substance abuse, sever selfharm, anorexia)
- Egostrenght; resources; support system, current family, social /financial situation

Attachment, Trauma, and Dissociation

- The majority of traumatized patients have disorganized (preoccupied, unresolved) attachment
- D-attachment has been shown to be associated with chronic dissociation and dissociative disorders over the course of development (e.g., Ogawa et al., 1997)
- D-attachment is a dissociative organization of the personality that is activated by relational triggers
- Unsolvable conflict between approach and avoidance
- One part of the personality engages in approach, while another engages in mobilizing (fight, flight) or immobilizing (freeze, collapse) defenses

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Trauma history

- Do not take an extensive trauma history (of the past) during initial assessment
- If possible, use information from earlier treatments
- Discuss with the patient the rationale for not going into detail
- Rationale is danger of triggering traumatic material and parts stuck in trauma time, too early

39

Treatment

Treatment For Complex PTSD and Dissociative disorders Is always Phase- oriented

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Phase-Oriented Treatment

- **Phase I** – Safety, skills building, stabilization, and symptom reduction; establishing the therapeutic alliance
- **Phase II** – Treatment of traumatic memories and related symptoms; working through the transference
- **Phase III** – Personality integration, mourning, and reconnection; promoting intimacy

The Need for Stabilization

- Because developmental trauma involves long-standing and pervasive developmental deficits in integration (including dissociation, dysregulation, and disorganized attachment),
- a (long) period of stabilization and skills building is necessary prior to work with traumatic memories.
- Thus, treatment is phase-oriented.
- Each phase is equally important. Stabilization, Safety and Enhancement of Positive Experience and Affect *are* the work as much as dealing with traumatic memory.

Why Stabilization Skills for survivors of chronic trauma?

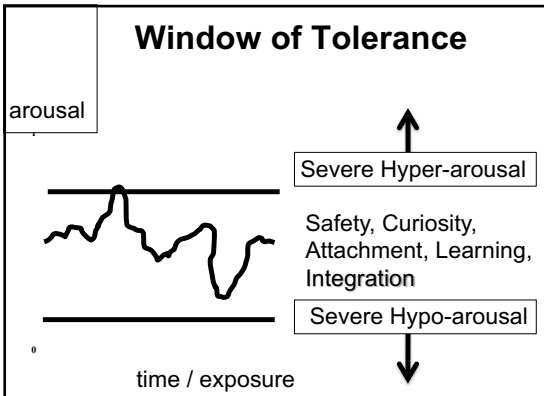
- Patients lack skills to cope with daily life and relationships
- Patients lack skills to cope with their inner experience
- Premature delving into traumatic memories can easily lead to decompensation and/or further avoidance without skills
- Skills deficits are the result of trauma and are an integral part of healing.

General overview of goals and treatment principles in stabilization phase

Need for Specialized Skills for patients with CPTSD and Dissociative Disorders

- Patients with a Complex PTSD and DD may not be able to make best use of classical DBT or PTSD treatment programs and skills training because their affects, cognitions, and behaviors are often dissociated and inaccessible by traditional means. Emotions and body sensations are ego dystonic: they do not "own" them (even if they know "it's all me"!)
- They need skills to address PTSD symptoms and dissociation and their dissociative self states/parts but first have to overcome their fear of these parts or self states.

Window of Tolerance



Adapted from Ogden et al., 2006; Siegel, 1999; Van der Hart, Nijenhuis, & Steele, 2006

PHASE I : GOALS (I)

- ESTABLISMENT OF A WORKING ALLIENCE/THERAPEUTIC RELATIONSHIP (PATIENT HAS TO OVERCOME PHOBIA FOR ATTACHMENT)
- EVALUATION OF BASIC COGNITIVE SCHEMA'S ON ATTACHMENT
- SETTING THE TREATMENT FRAME; BE CLEAR ABOUT WHAT PATIENT CAN EXPECT FROM YOU; BE CLEAR ABOUT BOUNDARIES

PHASE I: GOALS (II)

- ENHANCING PATIENT'S EGO STRENGTS/CAPACITIES
- LEARNING TO REFLECT; GETTING NEW PERSPECTIVES
- CREATING MORE STABILITY IN PATIENT'S DAILY LIFE THROUGH INTERVENTIONS AIMING AT SELF-CARE, DAY-NIGHT RYTHM, SAFETY, FOOD, SOCIAL SUPPORT SYSTEM, HEALTH, WORK, REST, PLAY ETC.

LEARNING TO REFLECT

BECOMING AWARE OF DIFFERENT AND NEW PERSPECTIVES

Improving Sleep

Healthy Eating Habits

Waiting For Salmon To Catch

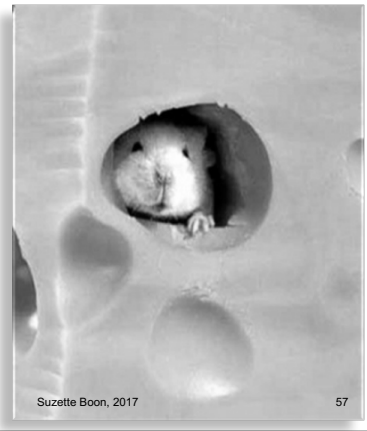
Self care Skills

Free time and Relaxation

Phase I: Goals (III)

- Psycho-education on dissociation as survival or coping stategy; on (complex) PTSD; on attachment issues (desperately want attachment versus focussed on destruction of any attachment; phobia for attachment)
- Teaching skills to cope with reactived traumatic memories; flasbacks and other PTSD symptoms; safe places; containment
- Teaching skills to improve affect regulation through using self regulation and auto regulationTHROUGH

Safe Spaces



Self Regulation Skills

Interpersonal Regulation

Phase I: Goals (IV)

- Teaching techniques to prevent/control selfdestructive behaviors; agressive reenactments of the trauma
- Promoting better understanding of and cooperation among dissociative personalities (ANP's, EP's) (overcoming phobia for dissociative parts of the person)

Promoting Inner Cooperation

Phase I : Goals (V)

- Protocol for crisismanagement, safety and (if necessary) short term hospital admissions
- Interventions in the patients current social system: spouse,children, friends (focus on psychoducation and/or relation/system therapy)

Factors facilitating treatment of complex dissociative disorders (1)

- Optimal clarity about treatment frame and boundaries (frequency of sessions, holidays, availability between sesions; crisis management)
- Clearly stated shared treatment goals (short and longer term)
- Dealing adequately with transference/countertransference issues

Factors facilitating treatment of complex dissociative disorders (2)

- Going slow in beginning stages ("pacing the therapy")
- First teach techniques for containtment of feelings/memories
- Do not go into traumatic material (but explain why!)
- Do not map all dissociative parts; start working with parts that have function in daily life (ANPs)

Factors facilitating treatment of complex dissociative disorders (3)

- Dealing with anger and self-destrcutive behavior/antagonistic parts of the person
- Talking through to "inner leaders" and angry parts (" perpetrator speech")
- Therapist needs intervision/supervision
- Prevent splitting in case of different treatment modalities/therapists

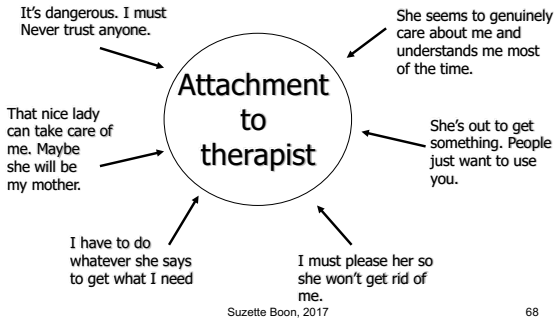
Most important aspect of initial stage of therapy

Overcoming phobia for contact with and attachment to therapist; working towards stable therapeutic relationship

What needs to be stabilised?

- Intense inner conflicts with regard to therapy and possible attachment to therapist: resulting in increase of phobia of host (or ANP's) for other parts inside (especially angry parts and parts that "do not want" therapy). Increase of war and conflict amoung dissociative personalities
- Tendency to manage "affect regulation" through self harm including "inner reactivation of traumatic memories, feelings etc."
- Tendency to destroy functioning in daily life (functioning of ANP's)

Conflicts Among Parts with Regard to Therapy & Therapist



The patient's Perception of the Therapist

- The therapist will be simultaneously be seen as:
  - A savior
  - Incompetent
  - Useless
  - Dangerous
  - Controlling
  - Devious
  - As always having a hidden agenda
  - Being on the verge of leaving or terminating with the patient

Transference

- Multiple, contradictory transferences
- Projective identification
- Don't assume the overt transference is the only one operating
- Appeasement based "quasi" positive transference should not be assumed to be positive
- Most of the essential work is in the negative transference
- Traumatic transference

Countertransference

- Whatever I do is not good enough; my patient rejects everything I do for him/her;
- This patient is so demanding, s/he takes all my time and energy, and doesn't take any responsibility him/herself
- I can't stand this patient and this a hopeless case. I want to refer out, but feel trapped.
- I am a failure as therapist; I am just as hopeless as the patient; I feel ashamed.

Countertransference

- This patient has suffered so much, I have to help her/him; if necessary I will do more than is "recommended," because this is a very special case (and none of my colleagues understand, so I don't talk about him/her)
- In this special situation I can give my private phone number because nobody else would understand or could help my patient
- It is absolutely fascinating to work with this patient, she/he is so marvelous, strong, talented, creative.
- I secretly believe I can love this patient into health.
- She will decompensate or kill herself if I set limits or terminate.

Working alliance with angry persecutory parts

- Therapist gives "Protector speech'' directly at beginning of treatment (has to be repeated over and over)
- Psychoeducation about typical "perpetrator cognitions"
- Psychoeducation about typical attachment problems of "perpetrator parts"
- Teach about dependency, autonomy, and healthy interdependency

Boon, 2016

Working with angry and persecutory parts

- Patient is usually very afraid of these parts, does not want anything to do with them (critical voices)
- EP's are also very afraid, they usually think that these parts are actual external perpetrators
- Persecutory parts are afraid of therapist and don't want to give up "power position" (afraid therapist will never want to work with them, hate/despise them, will get rid of them

Boon, 2016

Reframing persecutors as protectors (1)

- Angry parts are parts of the self who have come to protect
- They:

(1) Have a very lonely position
(2) Keep "worst" feelings of anger, shame, powerlessness
(3) Are terrified of crying, sadness, weakness
(4) Are terrified that they will disappear
(5) Have extremely bad feelings about self
(6) Think that therapist will never want to work with them
(7) Believe that either they get destroyed by therapist or they destroy therapist
(8) Lack any cognition about healthy interdependency

Boon, 2016
Suzette Boon (2008)

Reframing persecutors as protectors (2)

- They are important and part of the self
- They are not going to disappear or die
- They can learn to cope in a different way with feelings of anger, rage,powerlessness
- They will stay in control even if they work together with therapist
- They are not weak or losers if they work together with therapist
- They are not losers if they feel vulnerable or cry!

Boon, 2016
Suzette Boon (2008)

Pitfalls in therapy with patients with complex DD (1)

- Insufficient assessment
- Problems with treatment frame; limit setting and boundaries
- Problems with management of transference and countertransference
- Problems with pacing the therapy

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Suzette Boon (2008)
77

Contraindications to phase II work

- lack of sufficient ego capacities
- Comorbidity on Axis I: severe other disorders
- Comorbidity on Axis II: severe personality disorder
- Patient's life cycle phase
- Lack of functioning in daily life

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78

Contraindications to Phase II Work

- Lack of responsibility for working in treatment
- Complexity of trauma history
- Total amnesia for trauma, sometimes with ongoing abuse

Phase II.

Treatment of Traumatic Memories

Phase 2: Goals

- Overcoming the phobia of traumatic memories
- Containment of re-experiences
- Synthesis
- Realization
- Personification

Before starting any trauma work

- Use grounding and orienting information
- Affect regulation (auto- regulation) and some mentalization necessary first
- Therapeutic relationship is needed as a regulator (interactive regulation) including relationship with perpetrator imitating parts
- Pacing is essential
- Always be aware of the tension between knowing and not knowing in a patient

Pacing the Therapy

Countertransference in Dealing with Traumatic Memories

- (1) undue fascination with the content of and a counterphobic attitude toward the patient's traumatic memories. This may result in undue and premature focus on traumatic material, and neglect of the development of the patient's essential daily life and regulatory skills.
  - Van der Hart, Nijenhuis, & Steele (2006, p. 322)

Countertransference in Dealing with Traumatic Memories

- (2) the therapist may overidentify with the patient's lack of realization, colluding to avoid dealing with traumatic memories at all.
- The therapist should assidiously examine his or her motivations and how these intersect with standard of care interventions and the therapeutic process.
  - Van der Hart, Nijenhuis, & Steele (2006, p. 322)

Countertransference in Dealing with Traumatic Memories

- It is easy for the therapist to become overwhelmed with patients' traumatic experiences, and find their emotional suffering and extreme loneliness difficult to bear.
- Thus the therapist should regularly engage in consultation or personal therapy, and have colleagues with whom they can resolve their own overwhelming feelings.
  - Van der Hart, Nijenhuis, & Steele (2006, p. 322)

Techniques

- Hypnotic techniques (e.g. affect bridge, exploration with hypnosis using imaginary video screen
- Exposure techniques
- EMDR adaptation of standard protocol
- Guided Synthesis technique

Exposure

- Exposure per se supports recall and awareness of traumatic events. But this is not sufficient in and of itself.
- Realization is an ongoing mental endeavor that allows for full integration of what is remembered

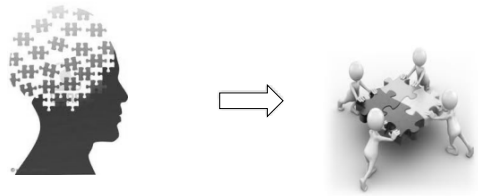
Exposure

- Exposure treatments (e.g., synthesis technique, EMDR, Hypnosis) MUST take into account the fact that a traumatized person is not integrated.
- Dissociated material may be far too intense for tolerance, while the patient presents with a numb, depersonalized, but "apparently normal" façade, leading the therapist to mistakenly belief the material is integrated

Synthesis Technique

- a controlled therapeutic action, designed to assist patients recall and accept various sensorimotor dimensions, affects, cognitions--of traumatic memory, *while remaining in the present and in contact with the therapist*
- The patient should **NOT** relive traumatic experiences
- Exposure on occurs in many small steps during Phase I, with a more intense focus on trauma content in Phase 2

Phase 3: Personality (Re)integration and (Re)habilitation



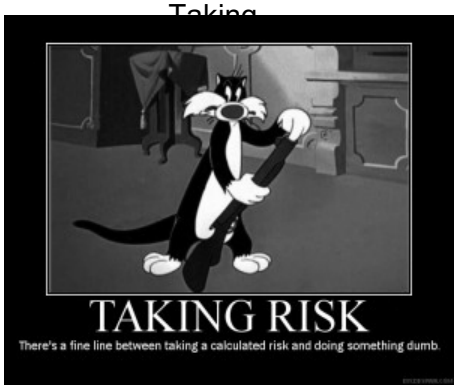
Phase 3

Overcoming Phobia of Attachment and intimacy with others

Phase 3

Overcoming phobia of daily life and change

Phase 3: Overcoming Phobia of Risk-Taking



Phase 3: Goals

- Grief work
- Resolution of existential crises
- Resolution of traumatic rage/anger
- Connection to the present
- Development of a (somewhat) detailed narrative *without* sensorimotor properties
- "I" experiences own history
- Use of soothing, comfort, and grounding
- Empathy for self

Phase 3: Goals

- Full investment in the present
- Body and sexual issues
- Development and refinement of personal ethics
- Relationship skills for intimacy

Phase 3 Treatment

- Solidification of non-dissociative and non-avoidant skills
- Higher order, reflective actions become habitual
- Processing of later emergence of traumatic memories
- Gradual movement into normal life and relationships
- Increased intimacy
- Evaluation and change of basic assumptions

Van der Hart, Nijenhuis & Steele, 2000

The End

PTSD and CPTSD self report scales

- **Davidson Trauma Scale (**Davidson, et al (1997).
- **The Impact of Event Scale - Revised**. Weiss, D. S., & Marmar, C. R. (1996).
- **Self-Report Inventory for Disorders of Extreme Stress" (SIDES-SR) (Spinazola et all, 2001)**

Structured interviews for PTSD and CPTSD

- Clinician administered PTSD scale (CAPS)

(Blake et al, 1995)

- Structured Interview of Disorders of Extreme Stress (SIDES) (Pelcovitz et al.1997)

Screening instruments for dissociative symptoms (all self-report)

- DES (dissociative experiences scale, Bernstein and Putnam, 1986)
- SDQ-20 (somatoform dissociation questionaire, Nijenhuis et all, 1996)
- MID (multidimensional inventory of dissociation,(Dell, 2002, 2006)

Structured interviews DD

- DDIS (Dissociative Disorders Interview Schedule, Ross, 1989, Ross et all, 1989)
- SCID-D (Structured Clinical Interview for DSM-IV Dissociative Disorders, Steinberg, 1995, 2000, (Dutch translation and validation Boon & Draijer, 1993)
- TADS-I (Trauma and Dissociation Symptoms Interview); revised version of former IDDTS (adapated to DSM-5 and ICD-11; is currently field-tested)