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# The Dynamic Therapy Model in Treating Complex Trauma Syndrome

Vito Zepinic[a],*

[a]PsychClinic P/L, London, UK.
*Corresponding author.

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## Abstract

Severe trauma such as the war combat, being taken as a hostage, brutal or repeated rape, affects all structures of the victim's personality—one's image of the body and sense of self; and one's values and ideals—and leads to a sense that coherence and continuity of the self is systematically broken down. Severe trauma overwhelms the ordinary human adaptation and resistance as it usually involves the threat to life or bodily integrity and confronts the victim with the extremities of the helplessness, hopelessness, and terror, and evokes the response of catastrophe. In this paper, we describe how effectively the complex trauma is treated using the Dynamic Therapy model.

We recognised five major alterations of the self as the aftermaths of severe trauma that should be targeted during treatment: (a) regulation of affected impulses; (b) attention and consciousness; (c) self-perception; (d) perception of the perpetrator; and (e) relation to others.

The Dynamic Therapy model is the three-phase oriented treatment which applies to *holotropic* integration of the distorted self into a whole: (a) Impulse containment; Engagement; Safety; (b) Understanding; Recalling traumatic memories; (c) Self-conception; Enhancing daily living; Relapse prevention; Independency; Steps forward.

The main concept of Dynamic Therapy model includes three treatment goals: (a) restoration of a form of the relatedness (*"Interconnectivity"*); (b) restoration of a sense of the aliveness/vitality (*"Dynamism"*); and (c) restoration of an awareness of self and inner events (*"Insight"*).

**Key words:** Complex trauma syndrome; Sense of self; Self-continuity; Interconnectivity; Dynamism; Insight

## INTRODUCTION

The main aim of this article is to give a contribution to the treatment of complex issues that appeared as outcomes of the severe traumatic experience. Disturbances of the self-structure by a severe trauma could cause the individual's spirit to break down, to be diminished, making the effective state flat and non-expressive—inert, lifeless, empty, and vacuous (Courtois & Ford, 2009; Herman, 1997; van der Kolk et al., 1996; Wilson & Drozdek, 2004; Zepinic, 2012). The victims of severe trauma may develop a sense of identity diffusion, fragility, and feelings of the self-discontinuity, with severe disruption in one's psychological equilibrium and interpersonal relationships. Severe trauma experience lies outside the normal range of a human comprehension and cannot be assimilated in part because it threatens basic assumptions about one's sense of self and place in the world. This assumption includes distorted trauma victim's personal safety, integrity, self-worth, and self-continuity (Zepinic, 2011).

The psychological sequelae following traumatic experience are usually a domino-like progression of the stress-response reactions. In case of severe trauma, it could permanently alter the self-cohesion and self-continuity of the trauma victim. The process of disintegration of the trauma victim's self may occur in two ways: (a) consciously expressed concerns related to the weak, vulnerable, and defective sense of self, and (b) out of the person's conscious awareness, disintegrated self is seen as a danger to the traumatised person and to the others (Zepinic, 2016). As a consequences of the self-discontinuity, the trauma victim is flooded with intrusive memories of the traumatic experience, as well as thoughts,

images and dreams (nightmares) with compounded levels of hyperarousal or flashbacks (van der Hurt et al., 2006; Wilson, 2006; Zepinic, 2012).

Treating disintegrated self is very complex issues, in particular using the standard stress-focused therapeutic approaches. The standard practice of debriefing after either natural or man-made disaster and catastrophes, severe fears of phobias after terrorist attack, brutal rape, or combat experience, could strike further development of complex stress-related condition because of re-traumatisation of the fresh traumatic experience. There is a united agreement among the clinicians that those who had been exposed to the severe, repetitive, or prolonged stressors should be seen as they are under risk of suffering complex trauma syndrome. To explain trauma symptoms, it is important to consider how much exposure to a life-threatening situation became conditioned to a wide variety of stimuli during the traumatic experience (Zepinic, 2016). As severe trauma inflicts a terror and fear which are increased by the inconsistent and unpredictable outbursts of the enforcement against the victim's self, the trauma inevitable leads to the losses of one's autonomy and all aspects of independent functioning, and even basic desire to survive (Zepinic, 2015).

The *trauma paradigm* of a complex trauma syndrome differs from the thesis of the diagnostic features of PTSD, which is severe and more complex. To understand the theory of complex trauma syndrome, it is necessary to clarify the traumatic event as an external event, causing severe psychological and/or physical upheaval with its lasting and crushing consequences of the victim's inner state of the self and its fragmentation. The sense of self and self-object losses is seen as the key to the physiology of traumatisation, and the stressor event and the self-system as ancillary to such losses (Ford et al., 2005; Schore, 2003; Ulman & Brothers, 1988). Those who are victimised, in particular by man-made trauma, are unable to understand, accept, or comprehend the trauma experience: they rather would *disappear,* if possible, from the real world which to them seems quite unsupportive, hopeless, and dangerous place for leaving (Burgess & Holstrom, 1974; Foa & Rothbaum, 2000; Gerson & Off, 2005).

In essence, the complex trauma paradigm is unique and differs from the thesis of single stress disorder diagnostic features (Allen, 2005; Courtois & Ford, 2009; Horowitz & Zilberg, 1983; Kartal & Kiropoulos, 2016; van der Kolk et al., 1996; Zepinic, 2015a). The diagnostic conceptualisation of the complex trauma syndrome is characterised by three main domains (Zepinic, 2011, 2016):

- The repeated reliving of traumatic memories which involves intense sensory and visual memories of the traumatic event accompanied by an extreme physiological and psychological distress and feelings of an emotional numbing. The intrusive memories can occur spontaneously or can be triggered by a range of real or symbolic stimuli.
- Avoidance of the reminders of the trauma-numbing, detachment, and emotional blunting which coexist with an intrusive recollection of the event. Intrusions are associated with an inability to react and experience a joy and pleasure, commonly followed by total withdrawal from any engagement in life.
- Increased arousal with the hyper-vigilance, irritability, memory and concentration dysfunctions, sleep disturbances (nightmares), flashbacks, and an exaggerated startle response. Traumatised people are easily distressed and distracted by an unexpected stimulus. Their perceptions are excessively focused on the search in finding the similarities between the present and the traumatic past, usually reinterpreting neutral experience associated with the traumatic event.

The clinicians are united that a longer course of treatment might be necessary for the effective treatment of complex trauma syndrome which is defined by the presence of a stable negative (disintegrated) self-concept (integrity and coherence), and avoidance of relationships (Herman, 1992; Cloitre et al., 2013; Courtois et al., 2005; Zepinic, 2011). Without meaningful ways to understand damages to one's self by the severe trauma, it would be like trying to understand degenerative neurological disorders without clear understanding how the brain functions.

## 1. THE CONCEPT OF THE DYNAMIC THERAPY MODEL

The posttraumatic growth of the traumatised self is based on three main domains (Zepinic, 2011): (a) changes in the perception of self; (b) changes in the experience of relationship with others; and (c) changes in one's general sense of purpose. Commonly there is a clear presentation of the wane, loss, diminishment, and destruction of important relationships in the severely traumatised patients, with a decrease sense of compassion and a critical view toward the others. Patients usually report they are "island" and not "part of the main". They need a greater sense of intimacy, closeness, and free to be again "the self", having desirable motivation to restore their own self strangled by the trauma experience.

The Dynamic Therapy model has been developed as a result of over a decade of research and therapy experience in providing treatment to severely traumatised individuals. This model, rather a process than a special technique, is used as a basis for intervention and is explicitly given as the rationale for the treatment of severely traumatised individuals in individual therapy. Suitability for using the Dynamic Therapy model in healing the one's traumatised

self is based on focussing attention upon the symptoms of complex trauma syndrome, and behaviour, and one's destructed sense of the personal being. The Dynamic Therapy model applies to a *holotropic* ("oriented toward wholeness" or "moving in the direction of wholeness") integration of the consciousness and the self (from the Greek *holos*, meaning "whole", and *trepein,* meaning "moving toward or in the direction of something). The main aims in using this therapy are (Zepinic, 2011):

- The restoration of a form of relatedness ("*Interconnectivity*")
- The restoration of a sense of aliveness/vitality ("*Dynamism*")
- The restoration of an awareness of self and inner events ("*Insight*")

*Interconnectivity* is an attempt to restore the core negative aftermaths of the trauma: disempowerment and disconnection from the self and others. The trauma survivor is in position to face tasks for creating a new future, new relatedness between the inner and the outer world, and rebuild a new self distorted by the trauma experience. However, helplessness and isolation are the strongest barriers in achieving the targeted goals: empowerment and reconnection. With sustained self-related disturbances, traumatised individual interferes both with new engagements and resolving issues with perpetrator and trauma attachment figures. Disturbances related to maladaptive fears and shame are interrelated and therapy should transform such disturbances related to the social environment (insecure and vulnerable to harm and/or worthless, and vulnerability to rejection and abandonment). Interventions for complex trauma syndrome patients in form of challenging the catastrophic expectations additionally address difficulties with interpersonal fears and distrust.

Therapy should bring an understanding that post-trauma symptoms represent patient's pathological exaggeration of a "dangerous world" and that the trauma survivor does not need "to protect himself from a danger". All fears and anxiety are related to the trauma symptoms and inner conflicts that prevent the patient from rebuilding a sense of power and control. On one level, self-exposure to the outer world with still existing inner conflicts can be seen as another re-enactment of the trauma experience. In the following insert of the therapy is illustrated by the patient's anxiousness and restricted effect towards the outer world:

Therapist: *May be, you can tell me what's bothering you?*

Patient: *I do not know… people, I guess.*

Therapist: *People? What is about people?*

Patient: *I do not know… I feel like they are closing in on me.*

Therapist: *You feel they are out to harm you?*

Patient: *I feel they can run over me any time and crush me… I would like to hide and stay at home all the time.*

The above extract from the therapy session indicates how the patient feels insecure in a social environment and has a fear of being hurt by others. The inner conflicts separated our patient from the outer world and made him withdrawn, isolated, and incapable for any relatedness. The therapy should provide learning as to how to control the bodily and emotional responses, and the inner impulses that bring the patient into uncertainty of a new relatedness with the outer world.

The sense of inevitable harm is organised around the fear, dread, and chronic anticipation of danger that generates into possible a new relatedness. The patient should learn to overcome a danger and be empowered to feelings that not every danger (internal or external) is an overwhelming experience and that not all fear and anxiety is terrible or threatening. Just as they must overcome their own fears and inner conflicts, they must also overcome these external social pressures; otherwise, they will be continually subjected to symbolic repetitions of the trauma in everyday life (Herman, 1992). This sense of vulnerability can lead to anticipating danger and catastrophic expectations due to the complex self-(dis)organisation and the perpetual feelings of disconnectedness.

*Dynamism* is seen as a transformation from altered and dysfunctional identity caused by the trauma experience into a functional one. It is not surprising for the patients who have experienced severe trauma to discover that disturbances of the psyche are more complex than it was assumed and that roots of the disturbances/dysfunction are incomparably deeper. Erikson (1968) spoke about "identity crisis"—a chaotic and profoundly confused mental state. While treating soldiers for "*battle neurosis*", he stated that all of them "did not know any more who they are… there was a distinct loss of ego identity… the sense of sameness and continuity and the belief in one's social role was gone". The outer and inner world of those who had experienced severe trauma has been shattered—their lives have continuously been inundated with the traumatic images.

The dysfunctional sense of aliveness/vitality is driven by unconscious needs and wishes from the traumatic past that play a greater role on the traumatised individuals than the present circumstances. Pathological forms of the patient's aliveness/vitality are identified by disturbances or alterations in the normally integrative functions of memory, identity, or consciousness. In essence, these pathological forms represent one's failure to integrate aspects of perception, memory, identity, and consciousness into the present time creating "feelings of strangeness", or "spacing out". The patient does not have control over the past (trauma experience) and experiences a sense of helplessness and loss of control over the body-self structure. This makes a dual function of the same individual delaying integration from the past into the present time.

Trauma itself can be regarded as a discontinuity of life experience.

It is essential not to ignore the facts that the past (trauma experience) plays a huge role in determining the present existence. In a sense that the past holds centre stage and influences the nature of present performances, the therapy should focus on the present time (*presentness*). In a trauma survivor, the *presentness* is defective and there is a ruptured practice of everyday life which seems difficult and unlikely to move from the influence of the past (Meares, 1987). The roots of this conception appear unconscious, however, they are in mind—perceptions, sensations, feelings, memories, dreams, and ideas—capturing a present mental state. Any patient's attempt to explore the external reality corresponds to what is in their mind from the traumatic past.

The trauma experience is mirrored and, when having memory about a past event, whatever is happening now is actually a conviction of the traumatic past. The trauma survivor's present time is a "prisoner or hostage" of the past, with no anticipation about the future. The past eclipses the present, casting so strong a shadow that *"here-and-now"* is always in shade and *presentness* can only confirm and affirm what happened in the past. To challenge this is to achieve a psychic equilibrium which the *presentness* desperately needs. The *presentness,* as a psychological entity, is meaning-oriented and perception-oriented, however, it misses the nature of its consciousness because of unconscious impact from the traumatic past. The phenomenological feature cannot be functional as awareness or consciousness is a necessary condition for the functional *presentness.*

The *presentness* is not only just one of ongoing experiences, but also is totally what is going on now. It is a compound of the perceptions, sensations, cognition, affects, feelings, and actions that presently act upon a traumatised person, consciously or unconsciously. In a sense that vitality is an affective attunement of the *presentness,* the therapy should bring into action the patient's acting and feeling for "*here-and-now*" concept. This tentative approach brings the patient to a daily exposure of not the present but the past experience—thoughts, emotions, and perceptions. All domains, modalities, and types of the situations perform a formation of the present framework of vitality and execution: interaction intentions, feelings, and thoughts. The patient's feelings become shaped by intentions, thoughts, and feelings of social environment not by the inner conflicts drive. The thoughts become co-created in a dialogue with the others, not by withdrawal or isolation. The mental condition is co-created by the individual's belongings to social environment changing intrapsychic phenomena which are "stamped" by the traumatic past. Therapy should transform the patient's fixed historical past into memories that are more present-centered than the past-centered (Stern 2004).

*Insight* seen as a self-continuity, regardless of the external circumstances or a generalised identity diffusion caused by trauma experience; it is quite an important part of therapeutic goals in the post-traumatic growth. Horowitz (1997) stated that without a sense of self-coherence and continuity, an individual is more likely to develop symptoms and explosive shifts in state of mind. Self-coherence is essential interpersonal style—it includes integrity and virtues within one's personality. The trauma experience shattered self-continuity and made identity diffusion with different or altered self-representation, split off one part of the self to another, and imposed a general blurring of the self.

An important question is whether the trauma experience universally damages the self-coherence and continuity. It is difficult to answer this question but traumatic experience brings one or another sort of the identity diffusion and inability. The trauma experience undoubtedly had a cataclysmic impact on an awareness of the self and accumulated negative emotions. Such negative stroke on the self affects a sensitised soil of the self which becomes relatively limited and discontinued. Often this experience can become so significant that we doubt self-potency in evoking emotional responses. This is because the traumatic experience is a consideration of a series of damaging events and the impact on the self cannot be undervalued.

Traumatic experience can impact one's self on two levels: it can be so devastating and destructive that no trauma survivor could be expected to cope with, or can "freeze" any growth and continuity of the self. Under the trauma condition, the capacity to strive, tolerate frustration, to channel aggression into the socially accepted outlets, ability to control impulses, and develop independency and self-assertiveness are shattered. In the course of this development by trauma, the patient is subjected to a lot of frustrations that involve abandonment of cooperative relationship within the group. The patient is not capable of handling such frustration having a great difficulty in relating to others.

The patients with impacted insight are often rejected and denied of legitimate demands, making them so overwhelmed by the feelings of helplessness that they will be never able to overrule the inner conflicts. They are unable to tolerate frustrations and/or withstand traumatic experience, which becomes a component of the posttraumatic growth. Such individuals are more likely to react catastrophically to relatively normal hardships than in a controlled way. The insecure patients feel so threatened by rejection or punishment that they will find it necessary to repress such impulses such as hostility towards their own self striving for mastery, independence, and the self-assertion.

Often, repression occurs dramatically following some external stress that convinces the patients that a danger can be real. The event constitutes a fear of relatedness

between the inner and the outer world. The fear will nevertheless persist, aiding the repressive process of the self. In the course of therapy, the recovery of the repressed traumatic experience may ameliorate or dissipate certain symptoms, especially those that serve the function of keeping these memories repressed (Herman, 1992; van der Hurt et al, 1993; van der Kolk & Fisler, 1995; Wilson & Drozdek, 2004; Zepinic, 2008; Zlotnick et al., 1999). The most dramatic results occur in simple conditional fear associated with a danger for physical existence such as accident or injury. This minor affecting stress can be seen like an exposure to unbearable stressors during natural disasters or war. The recall of forgotten memories becomes fully restored to the previous status (trauma experience).

All symptoms of shattered insight have their origin in lost awareness of the self and they are deep enough into the past, penetrating the myriad conditioning and prevent any new idea from entering the mind. Peering into all influences, it is a demonstration of how each of these symptoms has the power to divide the self into disconnected pieces. The therapy task is to recapture the divided fragments into one functional system. While doing this, the therapist may find, in most cases, that the symptoms themselves will not vanish easily and that the trauma experience will dominate on one's awareness of the self for a long period of time.

The expectations that the recovery of trauma experience will supress all inner conflicts should be considered cautiously. It is like an infection that operates insidiously on a body over a period of years. The original source of infection can be discovered and treated whilst the infection has already affected other bodily structures. The removal of primary focus can still leave the body infectious, and it is necessary to treat secondary effects before declaring that the problem is entirely healed. A single experience can likewise act as a focus engendering in an insecure individual a feeling that the world and its people are not to be trusted. This is a negative awareness of the self seen as being in constant danger of being hurt. By the time, this manner of keeping these conflicts has been structuralised into behaviour so ingrained that recall of the original trauma will have a little effect on habitual responses. The therapy should involve the re-education and reconditioning of the current symptoms originated by trauma experience.

Often during the therapy, the patient recovers forgotten memories of the traumatic event and can recall considerable amount and details of the trauma experience. He liberates himself from certain associated symptoms; however, the essential difficulties of the self-awareness may still exist at a deep unconscious level. The circumstances that revoke the original traumatic scenes may continue to plague the patient's mind. However, both the therapist and the patient should remain alert for possible re-experiencing of the trauma event that is not a relapse but a part of the residually existing forgotten trauma memories. This can make the patient insecure about the therapy progress and deteriorate the self-awareness and daily interpersonal relationships that were developed.

Thus, the essential goals of restoration of awareness of the self and the inner events are not only to recover from a traumatic condition presented and reported as the conscious experience, but also to ascertain why and how the unconscious inner events (conflicts) become so powerful and catastrophic (necessitating repression) that shatter the patient's steps away from the traumatic past (Allen, 2005; van der Kolk et al., 1996; Zepinic, 2008). These reactions, patterns, and attitudes, derived from the past (traumatic experience) may induce repetitive maladaptive forms of behaviour motivated by a desire to escape from the helplessness, to gratify the essential needs, and to avoid fears, anxiety, and potential hostility. The traumatised individual reacts to the present time with uncertain mechanisms of adaptation rooted in his past traumatic experience, and current problems are a result of the inner conflicts and external demands, fears, and resentments that arise from the interpersonal relationships.

The therapy should provide ways to reduce the compulsive impulses from the past which drive the patient into isolation and a stasis of the self-continuity. These accumulated inner conflicts consequently do block the self-development and the self-awareness, diminishing the ability to tolerate anxious expectations. It is a usual autonomic imbalance of complex trauma syndrome accompanied by the effect of anxiety in the chronic form of the disturbances (residual irritability). The repression is an exhausting condition causing a fixation on the trauma, typical dream life (dreams of annihilation, frustration, defeatism), contraction of the general level of functioning with constant fear of outer world, lowered efficiency, disorganised behaviour, lack of coordinated goal activities, profoundly altered functioning in the automatic, motor, or sensory nervous system, general irritability, and explosive aggressive reactions. The patient's overemphasis of the parts influenced by the traumatic past my produce unfortunate effects of the therapy, finding justification for the resistance to change. The therapy may reduce the compulsive impulses developing the patient's isolation from the present time. Some patients may be led to believe that awareness of their past conditioning will be dissolved by their non-reintegration with the world. Consequently, they will continue to search for stereotyped behaviour of withdrawal accompanied by fear, anxiety, and residual irritability.

Knowledge about roots of the inner conflicts ultimately contributes to understanding the complex trauma syndrome and bring tremendous value in establishing treatment strategy of one's self-continuity recovery. It points to the patient's weakness and sensitivity of the self at the time of the particular trauma experience. It further brings the awareness of repetitive happenings (residual

irritability) at the present time as a reflection of the unconsciously memorised trauma event. Of particular therapeutic benefit is that the self withstands the inner conflicts and accompanied negative emotions liberated by the recall of a trauma experience. During therapy, the patient may report how he often has little respect for his own self because it is overwhelmed by fears of the past. The traumatised individual is not able to master these impulses, fears, and tolerate extreme anxiety that causes him to be "frozen" by the iceberg of the unconsciousness. This has an enhancing impact on vulnerable self, leading to further depletion and inconsistency.

The therapeutic framework of the Dynamic Therapy model includes the "*C*"*s* concept: *connection, creativity, compassion, coping, contingency, co-construction, cohesion,* and *consciousness*. This comprehensive set of the components, rather than presenting an alternative means of reparation and healing, constitutes complementary elements, all of which need to be applied to the trauma survivor. Even under the optimal conditions, traumatised individuals have mixed reactions to the provided therapy and mixed feelings in participating in therapy that can be completely anti-therapeutic.

*Connection* stems from a need to connect parallel self-operations into a network rather than a sequence. This means that the inner un-relatedness should be found and stored in/inter, and connected into one functional system as a whole and coherent.

*Creativity* is seen as relating/involving/giving something new than a stereotyped patient's behaviour and relatedness. It is a process of derivative sublimations: self-representation becomes possible, imagination is enhanced, and the innate mind drives toward the sense of discovering one's real self. This assumption of unity of the individual is an attempt to create a unified personality regardless of the one's life experience (trauma) and forms of expression (traumatised self). The key concepts are: Expectations about the future rather than relying on traumatic past; innate tendency to develop capacities to the fullest and to relate with the others; interpret experience; and, alignment with responses instead of suffering.

*Compassion* is the therapist's approach to a patient's "*here-and-now*" subjective experience and shows therapy directions (willingness). Conversation between the therapist and the patient should be seen as two arms linked by a movable joint (posttraumatic growth), contriving to accomplish a valued self.

*Coping* predominantly means successfully meeting challenges in trauma symptoms and dysfunctions impacted by the trauma experience. The patient should use the coping mechanisms while adjusting consciously and unconsciously, to environmental demands. Instead of being an "*island*", the patient should move to be "*part of the main*" without altering his/her goals or purposes.

*Contingency* is defined as the unfolding therapist-patient relationship, the integral part in the communication/conversation sufficient to elicit the result (healing the traumatised self and made the posttraumatic growth). Targeting and fostering "*aliveness/togetherness*" the therapy aims are correcting one's maladaptive forms of relating.

*Co-construction* includes the elaboration of unconscious products (dreams, fantasies, etc.) which could be a symbolic expression of the one's past (traumatic) experience. In co-construction the therapist shares an experience and co-creates into therapeutic dialogue and relatedness, verbal or non-verbal communication, deepening the sense of clarity and communion.

*Complexity* is one joined (shared) experience during therapy; an interpersonal therapist-patient relatedness which enables the traumatised self to achieve more stable, flexible, and more adaptive states. The patient's self is traumatised, depleted or shattered, and complicated by reverse of growth, and idealised figures less formidable as their strength is internalised with gradual de-idealisation ("me and others"). The images are concrete, with resultant distortions and condensations that run into depletion of the self-values.

*Cohesion* is defined as the sense of self becoming whole but also the action of forming a unit and a whole, a sense of trust: Growing connection between the therapist and the patient towards the posttraumatic growth—the full repair of ruptures, enabling patient to experience a sense of cohesion and coherence across the various states of mind. The therapy is aimed in producing a cohesive self—the stable and adequately structured sense of one's identity even in the face of having a traumatised self. The pathology of such self is a mirror reflection of an unstable self whose cohesiveness has experienced severe break-ups. While achieving the cohesive self, the therapy should consist of a progressive consolidation, sensitive and emphatic, with the "self-object" figure good enough to support the restoration of ego strength into a self-worth and a self-assertive state.

One of the main principle of the Dynamic Therapy model is that the therapist must be able to communicate clearly and give explanation of the patient's suffered complex trauma syndrome at the first session and reiterate it throughout the therapy adding new information about comorbid condition. Clear case formulation is also part of therapeutic approach helping the patient to develop a therapeutic alliance and cooperation through the therapy. Severely traumatised patients are usually confused and troubled by complex trauma syndrome and often have some ideas that add to the mystery and threat of their disturbed personality and functioning. For the patient, it is important to recognise eventual exaggeration of the comorbid condition, automatic thinking, and/or maladaptive emotions and behaviour. The patient's numerous complaints about symptoms often create confusion as to where to start and what could be achieved throughout the therapy. However, the most

important task in any therapeutic approach is the patient's safety. Inevitable, the severely traumatised patient has misconceptions about comorbid condition and correcting this could be also one of the first tasks of therapy. The patient often believes that the complex trauma syndrome cannot be healed and that he/she loses contact with reality, reporting extreme helplessness and desperation.

The Dynamic Therapy model theoretic construct deals with the following concepts: (a) the nature of the predisposing factors in complex trauma, (b) the manner in which the trauma experience and conditioning produce distortions in the trauma victim's personality, (c) the relationship between the personality structure and trauma, (d) the constituents of inner conflicts, (e) meaning, function and manifestations of the complex trauma syndrome, (f) the structure of the psychic apparatus, and (g) the mechanisms of defence. Patients with complex trauma syndrome show dysregulation in the areas of emotions, thoughts, behaviour, intra-and interpersonal relationships. They can be compared with the patients who suffered severe burns and have no emotional skin to protect them from painful memories. They often cannot make clear and sensitive distinction between who must be responsible for their comorbid condition: their own vulnerable self or others. This is a key point in treating severe trauma survivor's insight while the therapist attempts to introduce changes and reinforce self-valuation and self-continuity.

The Dynamic Therapy model focuses on the effect of traumatic experience on the patient's prior self-object experiences, self-values, altered experience of safety, and loss of the self-cohesiveness. This helps the patient to maintain and identify a dysfunctional sense of self in the face of trauma. The model is useful in addressing the subjective and interpersonal sustaining factors of the trauma aftermaths (e.g., issues in trust of the outer world, shattered assumptions about attachments), as well as changes in the beliefs that the external world is a dangerous place. The severely traumatised patient has widely altered perceptions related to the feeling that a threat is inevitable. This is a chronic state that requires employing a mixture of supportive and insight-oriented interventions, based on the individual's symptoms, developmental history, personality, and ability to tolerate exploration of the trauma effects. In Dynamic Therapy model, the issues of transference are often explored to help the patient understand conscious and unconscious concerns (inner conflicts) surrounding the meaning of trauma experience.

## 2. THREE PHASES OF THE DYNAMIC THERAPY MODEL

The Dynamic Therapy model contains three interconnected phases of the treatment individually designed and based on the assessment findings. The heart of therapeutic approach is sharing with the patient formulation of the complex trauma syndrome symptoms, to elicit feedback of the therapy sessions, and make necessary adjustment during the therapy. The Dynamic Therapy model cannot be regarded as a general psychodynamic or psychoanalytic therapy or any other specific therapeutic model: it uses suitable elements from the different therapeutic techniques, putting them into one effective therapy model— Dynamic Therapy.

In severely traumatised individuals, the inner conflicts drive is unconscious creating fears, anxiety, and enhanced resistance and, instead of battering down the patient's resistances using the cognitive restructuring, the Dynamic Therapy model gives full freedom to recall when the patient feels capable of handling traumatic memories. Some of the traumatic memories, because of their painful nature, can be forgotten but they are quite important as they can induce inner conflicts at any time. However, during therapy the patients cannot be "forced" to revoke them from amnesic state but has to leave them until a stage when the patient gains full control over the inner conflicts. When achieving such stage, the forgotten memories then will not have any more catastrophic impact on the patient's inner world, and the patient is able to tolerate and control isolated fragments of these memories.

The Dynamic Therapy model is: (a) goal-directed towards specific objectives caused by trauma experience, (b) it is organised around a relationship between the therapist and the patient, (c) it includes continuation of the assessment and case formulation, and (d) it evokes emotional responses in the patient which must be therapeutically handled. The goals in treatment consist of a relief of trauma symptoms and better adaptation in areas of living in which the patient has failed, reorganisation of the attitudes and values within expansion of the personality assets, and an alteration of the basic structure of the one's character with creation of potentialities that were thwarted by trauma.

### 2.1 Early Phase of Treatment: Impulse Containment, Engagement, Stabilisation

Regardless of the actual resources in making referral for assessment and treatment, most trauma patients come for therapy at a time when defences are broken and evidenced "*here-and-now*" dysfunctions. Many of our patients reported that, up to one year after the traumatic event is over, they functioned within their "ups and downs", in essence being aware that the trauma is not over for them. Their maladaptive feelings and traumatic memories become more impacting on their everyday life, relatedness, and self-conception. At the time requesting treatment, the patient's coping resources are usually overstretched and everything in life is overwhelmed by horrible memories. They report dysfunction or even total loss in many domains—struggles with the others,

complaints regarding social relationships, having arguments or tense reactions with loved ones or even with the own self. Some report that loneliness and alienation, as well as avoidance by others, was "red light" to seek the treatment. Their past, present, and future have become somatically, emotionally, and cognitively confused—reactivated traumatic memories in the form of intrusive affects and bodily sensations signal danger even in peaceful moments (Ogden et al., 2006).

The trauma patients report avoidance in daily life with their attention focused mainly on threat cues or on internal dysregulation. They also report they spend little or no time thinking about relationships, emotions, and maladaptive psychological factors that affect their everyday life. They get "accustomed" to be aside, isolated, and withdrawn and for them it is easy to continue along with trajectory than to change. They often do not see a meaningful connection between their traumatic past and present time, still being in "*there-and-then*" than "*here-and-now*" circumstances.

The therapist has a very tough task of deciding from which standpoint to start the therapy. However, it is advisable in the early phase of treatment not to start exploring the traumatic memories as the patient is not ready for such therapeutic task and has not developed close therapeutic relationship. Instead, in the early phase the interventions should focus on stabilising the patient's physical and psychological state, emphasising the self-regulatory skills that maintain arousal within the therapeutic frame of tolerance, and reducing self-destructive tendencies and behaviour. Developing resources for stabilisation and the patient's integrative capacity for adaptive functioning in daily life increase the patient's safety and faith that help is available. The therapist's role is to evaluate with the patient to understand why the patient's condition is dysfunctional. The patient becomes aware of the reality of his weakness and this is an important component in helping him to accept that his vulnerability should be treated.

We emphasise that the early phase of treatment should help the patient to recognise the dysregulating emotions, arousal, and behaviour that can cause self-destructive reactions such as the self-harm, violence, dangerous activities, or any other forms of maladaptive behaviour. This makes the therapist overtake the role of a regulator of the patient's dysfunctional mental state, to adjust the pace and therapeutic process to help the patient to develop resources for a self-regulatory system.

The early phase of treatment involves the reinstatement of lost resources, strengthening existing or inventing new resources (personal skills, abilities, relationships). This will help the patient to facilitate the self-regulations, a sense of self-competence and resilience. Development of new resources or capacities should start with the acknowledgment and recognition of the existing resources such as the patient's ability to operate cognitively, as well as recognition of "*survival skills*" that enabled the patient to cope with posttraumatic challenges. Developing resources will help the patient to face and integrate the traumatic memories and foster competence and creativity to meet life's challenges.

During the early phase, one of the main tasks is to observe unconscious conflicts and the types of defences employed by the patient, which form a blueprint of the unconscious problems. This blueprint point should be utilised during the entire therapy provided. Since the repression is threatened by the process of exploring the unconsciousness, anxiety and fears are apt to appear supporting and stimulating the defensive mechanisms. These actions cause resistance to productivity and narrative that consequently may hold up the therapy progress and patient's cooperation with the therapy endeavour. Such resistances are dealt with the patient's interpretation of the external world (which is a "dangerous and unsafe place"), and own self (which is disported and shattered).

The therapist takes on the role of bringing patient to an awareness of how and why he is resisting, and the inner conflicts that make resistance and defences necessary. Sooner or later, the patient will transform past attitudes and feelings into a present therapeutic relationship with the therapist. Good therapeutic relationship is a basic rule, an attack on the resistance and the defences that will change the meaning of the therapist-patient relatedness. As the therapeutic relationship progresses, the patient will gradually remove habitual protective devices and facades that could create resistances to maintain the conventional relationships.

*Shaping therapeutic relationship* is a key point of the therapy considering that for the patient is not easy to talk about trauma that brings back to the feelings of terror or rage engendered by the trauma. Two essential goals must be achieved in therapeutic alliance: positive relationship and a sense of working together. The therapeutic alliance includes an active collaboration leading to the patient's feeling that the therapy is a *working together towards common goals* with the therapist's guidance and support.

In the early phase of treatment, with its theoretical and practical constructs, the therapy deals with: (a) the nature of one's maladaptive relatedness, (b) the manner in which the traumatic experience produced distortions in personality structures (the self), (c) the constituents of the inner conflicts, (d) the meaning, function, and manifestations of the trauma experience (Zepinic, 2011). All of these elements play a role in shaping the therapeutic relationship and most clinicians agreed that the early phase is the most important and complex as it includes a dealing with the overwhelming emotions and pathological operations. The early phase is a *stabilisation phase* in which the therapist deals with: identifying and labelling emotions; identifying and appropriately utilising social supports; focusing on the content rather than affects; scheduling, planning, and anticipating daily activities; making judicious use of exercise and food; and engaging

in relaxation and stress inoculation exercises (Herman, 1992; van der Hurt et al., 1993; Zepinic, 2011). All of these are part to establish the patient's trust and a feeling of the acceptance—the therapist is trustworthy, reliable, and striving to be helpful.

Early phase of treatment is a period when the therapist teaches the patient to evaluate own resources that might be used as a benefit by directing awareness to body sensation, areas of the tension or relaxation, movement, pain, discomfort, structure, and alignment. The patient should evaluate which capacities are functional and which need challenging. When we examine the authentic nature of disturbed attitudes, we realise that the patient has been victimised by trauma symptoms endlessly, again and again, during and after the trauma. This imposed a threat to his dependency needs and personal security, created a devaluated self, and impaired relationships with the others. The patient believes that he is unable to undertake any responsibilities on own shoulders as he is too vulnerable and weak to bear the burden of normalcy. As he is unable to manage the crisis and fears, his physical equilibrium is disrupted threatening his mastery and precipitating catastrophic fears and anticipations of further danger.

Due to the patient's vulnerability and psychological weakness, sometime physical too, the patient assumes very passive role, exhibiting little or no spontaneity and initiative and anticipating that his needs and demands cannot be fulfilled. His helplessness and fears add further psychological injury until the act of going to therapy creates challenges which bring back his capacities. Thus, this would serve to bring the patient to an awareness of the maladaptive attitudes and patterns that he habitually demonstrates in order to defend his weakness. It is of therapeutic benefit if the patient is able to recall the traumatic past that impacted such dysfunctional state and present defected levels of functioning, experience, patterns, competences, and strength.

The opening therapy sessions in the early phase should be seen as the meetings between two human beings—one who needs help and expects it and another who is able to provide help and is willing to do it (Zepinic, 2011). It is common to notice nervousness when the patient entering the therapist's office with tension and anxiety, and the body language that shows an emotional response to the therapy—gait peculiarities, fidgetiness while sitting in the chair, wringing of the hands, picking of the skin and lips, stiffening of posture, clenching of the fist, tapping of the toes and grimness in the facial expression. The therapist should always bear in mind that the severely traumatised individual is stigmatic, anxious, uncertain, and with a lot of anxiety and fears towards the therapy.

It is important that the therapist checks his own non-verbal expression to ascertain that he is not conveying disapproval, boredom, or irritation. Reassurance that therapist will do his best helping the patient to restore his disturbed psychological equilibrium is usually given in verbal form, however it is also stated in the therapist's non-verbal behaviour by maintaining a calm and the objective attitudes. The reassurance should not be used straightaway when the therapy starts as the patient may not yet have sufficient faith in the therapist to be convinced of the security. The patient may imagine that the therapist does not know how serious the condition really is or that he delivers therapy without deep confidence. If the therapist gives the reassurance, it should be after listening carefully and respectfully to what the patient points out. The patient will appreciate the therapist's listening even if some of the patient's comments are senseless or objections about therapy or clinician are premature.

One of the most necessary reassurance in the early phase of treatment is that the patient is not going to be insane. Panicky feelings, bizarre impulses, cognitive dysfunctions, and a sense of unreality and uncertainty lead the patient to such assumption. Because of the evidenced dysfunctions, he becomes convinced that he will lose control of mind and perhaps inflict an injury on himself or on others. The patient may attempt to justify his fear of insanity by revealing that he had trauma experience in which many people become insane although they were mentally stronger than the patient. He will attempt to convince the therapist that torture and horror imposed was so painful and unbearable that insanity must follow it. Under no circumstances should the patient be ridiculed because of this fear and the therapist essentially should show that the fear of insanity is a common post-trauma symptom. The patient should be reassured that he did not provide some evidence, neither reported symptoms, that insanity is a forthcoming state.

The most common reassurance needed for brutally raped victims is in regard to aspects of the individual's sexual life (Burgess & Holstrom, 1974; Foa & Rothbaum, 2000). Frigidity or loss of sexual desire, for instance, is the major concern of many victims. Projecting their sexual dysfunction, some women tend to blame their sexual identity as a reason of being raped and current sexual incompetence. In therapy, this misconception has to be carefully clarified with a therapy focused on the trauma experience rather than on sexual dysfunction. In men who were sexually abused as a child, reassurance may be required in cases of temporary impotence. This reassurance may be organised around the theme and episodes of the impotence, mostly focused on the trauma experience which has eventually been constant danger and an insult upon the person's dignity. These conditions normally inhibit real sexual desire, and the trauma victim's memories and sense of tension also inhibit one's sexual performances thereafter. With meaningful reassurance, the therapist strengthens the patient's sense of self and self-values, which are quite important for therapy in general.

If reported, it is recommended to work on dissociation in the early phase of treatment, and this should continue through the entire phase and during mid-phase of

treatment. Dissociation is generally described as an altered state of the consciousness which results in diminished awareness of the environmental events (Courtois & Ford, 2009; Foa et al., 2009; van der Hurt et al., 2006; Zepinic, 2016). The most recent edition of the DSM-5 (APA, 2013) clarified dissociative reactions (depersonalisation and derealisation) caused by the severe trauma creating profound disturbances of the traumatised personality. History of multiple types of traumatic events, chronicity and severity of trauma symptoms appear to be associated with dissociative reactions. Putnam (1989) stated that while treating over 70 combat veterans, they reported having experienced in the extreme detachment and depersonalisation during moments when they thought they were about to die or when they killed others. He was of opinion that depersonalisation syndrome frequently occurs in those trauma survivors who had been exposed to severe trauma or a life-threatening experience.

Patient's safety aim that is part of the early phase of treatment is focused on the safety endangered by disturbed patient's self. This vulnerability become extreme in dissociative identity disorder when the individual feels terrorised by dissociative states (Allen, 2006; van der Hurt et al., 2006; Zepinic, 2001). Herman (1992) stated that establishing safety is the first priority in treatment and emphasised the therapist's role in catering to the basic needs without exposing the patient to the danger of abuse at the hands of own self or others. Although suicidality is not diagnostic criterion for PTSD, in clinical practice this condition is often presented in particular with those patients who had experienced prolonged or repeated trauma. Severely traumatised individuals may find suicide as an "emergency solution" in order to escape from the "persistence of trauma" that continues into the post-trauma time (Zepinic, 2015). Depleted or shattered self has been afflicted with a sense of emptiness in painful intensity of traumatic memories, and "*self-at-worst*" is not able to cope with negative feelings as "nothing is inside".

There is no boundary when the therapy should move from the early phase into another one and this is more hypothetical than practical question. It is the therapist's judgment to estimate the patient's completion of the early phase and readiness for the next stage bearing in mind that every patient individually responds. In general, the transition should be gradual, not hurried, and a few sessions can be used to overlap two phases. It is a golden rule that clinical experience is never limited and it is never completed. At some point, the problems treated and already solved in the early phase may reoccur in particular when some trauma events are reminded causing temporary regression or relapse in the patient's condition.

### 2.2 Mid-Phase of Treatment: Deepening Understanding, Recalling Traumatic Memories

The mid-phase of treatment focuses on the trauma symptoms that include traumatic memories related to specific trauma experience. Traumatic memory system is organised as a complex structure of cognition, emotions, and tendencies to respond. Some authors (Meares, 1987; Putnam, 1989; van der Hurt et al., 2006) suggested that dissociation is a "coping strategy" that arises from the experience of extreme helplessness in the face of the trauma. They also found that an early dissociative response has been found to predict a worse outcome of the trauma. Hyer et al. (1996) in a study of 110 hospitalised Vietnam veterans found that chronic PTSD led to the use of emotion-focused and escape-avoidance strategies to cope with the traumatic memories. The traumatic memory system can be triggered by contextual cues which resemble the original trauma. These cues are usually external in their nature and might be produced by an object, person, circumstances, or even by a conversation. The therapist should bear in mind that trauma memories are split off from the patient's conscious awareness and stored as sensory perceptions, obsessive thoughts, and behavioural re-enactment. Because the trauma is not recollected as a coherent, autobiographical narrative, the trauma patients are unable to deal with the effects and implications of their memories by discussing or thinking about them.

As the patient's safety was treating aim in the early phase of treatment, this issue should continue through the mid-phase in particular when the trauma patient releases details about the trauma memories. Anything that threatens to disturb an individual's solution of the core conflict arouses a fear. Descending into this condition more and more and withdrawing from the "*here-and-now*" circumstances often creates proviso for suicide (Zepinic, 2001). The rise of anxiety and fear of the traumatic memory and inner impulses may result in both aggressive and regressive behaviour. While talking about traumatic memories, the individual's emotional pain might be the overwhelming experience from the perspective of the helpless trauma patients who became unable to tolerate and deal effectively with any kind of loss or pain. They cannot tolerate re-trauma and they are desperate to get out of it.

Many clinicians (Courtois & Ford, 2009; Foa et al., 2009; Herman, 1992; van der Hurt et al., 1993; van der Kolk et al., 1996; Zepinic, 2008; among others) are united in opinion that the therapy on traumatic memories is fundamental for the entire treatment of trauma-related problems. Effective processing of the traumatic experience requires specific therapeutic efforts and failure to adequately process the traumatic memories inevitable leads to chronic psychopathology. It is proposed (Zepinic, 2015a) that PTSD becomes treatment resistant condition when the patients process the trauma in a way that retains a sense of persistent threat or danger.

As many known therapeutic techniques are inapplicable to treat traumatic memories, the Dynamic Therapy model employs the modified *imagery exposure*

technique. In complex trauma syndrome, treating traumatic memories is quite complex and sensitive matter which could cause re-traumatisation. The aim of *imagery exposure* is to help the patient to confront fear and/or trauma-evoking stimuli and weaken distressing thoughts, emotions, and somatic arousal associated with the trauma event through the habituation and the correction of catastrophic misinterpretation of the presence, and significance of such experience. Although the exposure sometimes still may evoke fearful thoughts (e.g., imagination of a certain person, time, or place), this exposure gradually "expose" the patient to traumatic moments and desensitise catastrophic reactions.

The therapist should identify risk and protective factors and discuss these issues with the patient before starting to work on traumatic memories. The treatment of complex trauma syndrome and release of traumatic memories cannot be unrealistic promise that a "therapy will work"—otherwise condition of regression may occur with further "encapsulation" of the inner conflicts and traumatic memories. The therapist should bear in mind the patient's fear of releasing traumatic memories because of re-traumatisation. Overcoming fears of the traumatic memories involve gradual and one guided approach that is directed by the therapist's and the patient's work to transform the memories into a symbolic verbal account that is *personified* and *presentified*. This realisation results in an autobiographical narrative memory of the traumatic event and in actions that can be adapted to the present rather than to the traumatic past (van der Kolk et al., 2005; van der Hurt et al., 2006).

Before commencing therapy on traumatic memories, the therapist should review eventual existence of symptoms that could contraindicate work such as psychotic features, fixation on lower action tendencies, malignant regression, the physical conditions that lower the mental capacity, some ongoing distress, and other issue that involve the patient's unstable or diminished integrative capacity. The modified *imagery exposure* of the Dynamic Therapy model is based on two main components: *guided synthesis* and *guided realisation* of the memories. *Guided synthesis* involves modulated and controlled exposure to the traumatic memory in which the patient receives from the therapist to remain oriented and focused on the present time while synthesising the previously dissociative mental content of the traumatic memories. In essence, these represent affective, cognitive, sensorimotor, and behaviour components of the memories associated with various dissociative parts of the personality.

*Guided realisation* is an ongoing therapy process of helping the patient to realise the background of losses and suffering and move forward towards the higher levels of (adaptive) emotions, thinking, and behaviour. This cannot be expected to easily being admitted as the dissociative parts of personality may still have a strong power and show resistance to any changes. In line with these obstacles, the *imagery exposure* should demonstrate that the feared situation causes no harm. In such preparation, the patients are taught how to manage anxiety and fear of the traumatic memories and inner impulses by using relaxation techniques and visualising a modified imagery which does not cause re-traumatisation. The patients recount the traumatic event from the start to the end and imagine it as if it was happening again. They also experience the feelings they felt at the time when the trauma occurred, while recognising that they are in a safe environment (therapy session) and that the event is now just a memory. They imagine the event again and again…, enough times until they are able to control the thoughts and the emotions related to the traumatic event.

*Imagery exposure* is useful when a traumatic memory remains vague, despite effort to recall it through evaluation, description, exploration, or reflection of the traumatic past. With repeated imagines, the patient learns that no harm can occur at present, even when he thinks about the event and imagine being "*present there again*" with the same emotions and thoughts he has at the time when trauma occurred. Despite the apparent simplicity in *imagining exposure,* implementing such technique is not an easy task, as exposure can be challenging. This therapeutic technique involves the patient's recounting of the upsetting thought and images, writing or reading scripts containing the distressing materials, or making a recording of the fear-provoking material that is replayed until full habituation is achieved. This strategy allows the patient to confront an otherwise covert event and manipulation of the "*here-and-now*" situation by the traumatic past. Moreover, the repetition of fear-evoking material (e.g. via recording) is helpful in safety behaviour and ensures that the self-supervised (homework) exposure will incorporate confrontation with a real trigger.

Most severely traumatised individuals report of having visual images of danger in post-trauma time, or even during the therapy. When asked about the details of the memories, they report visual images that have the same nature and general content of the original trauma—that is one's anticipation of psychological trauma. The fantasies and memories often represent a distortion of reality which makes the patient scream desperately for help. It is common to find that feelings associated with the fantasies are more congruent with fictitious perception than with reality. In many cases, patients report visualising a scene of trauma as though it were actually occurring again. Patients believe that these fantasies are real, identical with the traumatic past and, in essence, are a continuum that cannot be disbelieved.

These unrealistic pictorial images are so powerful that one believes its authenticity which often misleads even the health professionals to think that the patient suffering from the hallucinations. We had numerous patients

being referred to the therapy due to visual or olfactory hallucinations, as the patients complained of suffering unreal but authentic images leading to the conclusion that they were suffering from psychosis. The therapist who is dealing with complex trauma syndrome will realise the beliefs in fantasy varies from moment to moment and is uncharacteristic for the psychosis. The traumatised individuals totally or partially confuse the fantasy with the reality until some reality test or evaluation analyses the content of the images. Even though the daydreams may be temporarily experienced as reality, the patients are able to regain their objectivity and label the phenomenon of fantasy (Beck et al., 2005). After analysing the nature of the fantasy, the fantasy can be experienced again, forcing the patient into a situation to test reality again.

Therapeutic approach in treating traumatic memories using *imagery exposure* is based on patient's experience of the fantasies of the traumatic event vividly or in the another ways experiencing. The exposure is focused on repeatedly experiencing imagining in a safe and controlled manner. It is a standard measure of systemic desensitisation used by Wolpe (1969) and Lazarus (1972) to resolve the patient's fantasies of a traumatic moment. The content of spontaneous images points to the cognitive distortions in a particular problem, and imagery procedures, such as induced imagery, can help the patient alter spontaneous fantasies, reality-test, and achieve distance from anxiety and fear (Beck et al., 2005).

In developing positive imagery, the therapist focuses attention on all sensual modalities: Taste, smell, hearing, vivid visual details that may support the patient in experiencing a full, safe *imagery exposure*:

> *Now I want you to close your eyes and imagine yourself in a garden of your home on a spring sunny day. You are sitting in a comfortable chair, drinking coffee, and watching a blossom in the neighbour's orchard. The sky is blue with a breeze and some clouds are floating above. You feel happy and relaxed. You smell the sweet smell of grass. Your perpetrator is walking on the street with his head down avoiding eye contact with you. You can hear birds singing, short pure whistles like saying to your perpetrator he is a bad person. You can almost initiate them. Looking closer, you see your perpetrator's red sweaty face but you do not feel any hatred or hurt… you just enjoy the sunny day. You feel completely calm and safe—just enjoy this scene for a few minutes.*

Although this imagery scene requires from the patient to feel relaxed and moving thinking about the perpetrator and torture away, the therapist expects a lot of the patient's startle responses while mentioning the traumatic moment. It is common that during therapy the patient may stop *imagery exposure* due to extreme reactions and feelings. Thus, the patient is encouraged to release and talk about his feelings and thoughts during imagery. This feared event actually happened but the patient is helped to overcome negative feelings and thoughts associated with it, without dreaded consequences suffered now. The imagery should be repeated with the homework practice, and some new relaxing elements should be added to make patient more relaxed and safer.

One of aims in working on traumatic memories is the cognitive reconstruction which helps in development of the self-awareness and restructure the patient's negative thought processes. Reconstructing thoughts is a necessary step in correcting distortions, and when increasing self-awareness, the patient realises how sufficient it is to correct errors in thinking. Self-awareness allows the patient to distance himself from faulty thinking and develop a more objective perspective towards a situation (Beck et al., 2005; Herman, 1992; Zepinic, 2011). With reported negative thoughts, the therapist becomes more aware and understands the patient's vulnerability, weakness, and difficulties in controlling his/her emotions and thoughts associated with complex trauma syndrome. The therapist is often in quite difficult position of summarising all negative thoughts as the trauma patient has experienced a lot of them. It is helpful to use a marker board to write them and then together with the patient categorise negative thoughts in order of their meaning to the patient. Frightening thoughts may cause other associated distortions such as emotions, behaviour, or relatedness, so that the patient should clarify which thoughts are the most frightening and should be processed first.

Reconstruction is a process which actually transforms the traumatic memory and thoughts about them. The concept of thoughts reconstruction is based on "the action of telling the story" principle. Although the traumatic memories are often wordless and deeply unconscious, the therapy overtakes a role as a "witness and ally" which encourages the trauma patient to speak freely and openly about something that seemed unspeakable. The therapist needs to clarify the severity of the meaning of negative thoughts to the patient so that more meaningful ones start to reconstruct. For success of the therapy, as well as to show respect for the patient's identification, the thoughts can be rated in accordance with the patient's opinion regardless of the eventual unreal categorisation. With severely disturbed thoughts and feelings about own self, we used reconstruction technique of the "*mirroring*". The "*mirroring*" is proto-conversation and primary intra-subjectivity that is attuned to the patient's present state. The role of vision is interaction with the "other", who is not able to respond or argue about the narrative. The patient and the "other" in the mirror have fixed eyes upon each other. It is a matching process, which is not equivalent to imitation as imitation is a static with nothing moving beyond it. In other words, the "*mirroring*" is a dynamism between the patient and the "other" (Zepinic, 2011).

It must be noted that *imagery exposure* treatment cannot start straightforward without the patient's readiness and willingness to do it. The therapist should explain that the *imagery exposure* aims to reduce anxiety and fears

associated with thinking about the traumatic event. With the patient, the therapist reviews the notion of "processing" the traumatic memories and addresses other aspects of the memories including those associated with anger and fear. Being fearful of releasing the traumatic memories is a normal feeling in traumatised individuals. However, as both the therapist and the patient already in the early phase developed therapeutic relationship and the reassurance that the therapy sessions are a safe environment, the *imagery exposure* is one continuum of such relations despite the patient's question "*Do I really have to do it*?". Once the distorted picture is fully recognised using *imagery exposure,* the patient then feels better and can handle the situation more successfully without fears of the traumatic memories.

The work on traumatic memories using the *imagery exposure* starts with the therapist explanation of the methods and targeted goals:

Therapist:*From today we will work on your traumatic memories which are a significant part of your trauma experience. As usual, we will record our sessions but this time you will have the opportunity to listen again and again to each session at home as the tape will be given to you. During review of the sessions you can make notes or drawing related to the remembered and released story.*

Patient: *I might start to cry and I will never stop.*

Therapist:*It is OK to release memories and telling story about the horror is not easy. Many patients also cried but did well and do not be ashamed of crying* (reassurance, emphatic attunement).

Patient: *Thank you doctor, I just know I do not like my past and I am scared of it, and I cannot stand fear* (negative evaluation conditioning).

Therapist:*It is quite reasonable to be afraid of revealing your traumatic memory* (further emphatic attunement). *We will work together. Monitoring your feelings and behaviour associated with the memories will be my priority* (further reassurance).

In the above sequences, it is evident that the patient's preparation to work on traumatic memories should be well oriented and grounded in a good and truthful relationship with the therapist. A carefully maintained approach helps the patient in taking a cognitive overview of traumatic memories. This can be obtained from some functional part of the personality which is less dissociated and has no big impact on the patient's mental actions. The therapist should closely observe eventual presence of any sign of an uncontrolled re-traumatisation. In the event of any re-experiencing or flashbacks, the work on traumatic memories should be avoided. It is essential that the patient feels safe and that the level of arousal does not become too high and overwhelming. Fears and re-dissociation of the traumatic memories are common accompanying problems, as well as being stuck in the memory in a hypoaroused state. This should be controlled, and in case of re-dissociation appearance, the therapy should be switched to treat evoked dissociation.

Work on dissociation started in the early phase of treatment and should continue during mid-phase, in particular on those dissociative reactions with amnesic state which usually disorient the patient. In this case, we asked patient to locate the last thing he remembers before the onset of amnesia. By repeating this procedure, we try to help the patient to isolate the experienced indicators that signal the dissociative reactions. During therapy sessions, the experienced therapist may recognise typical manifestations of dissociation such as apparent forgetfulness about matters in therapy session, abrupt changes in the subject of discourse, derailing of an ongoing conversation, fears or distress, difficulties in characterising alterations, changes in attitude, emotions, and viewpoint taken towards matters under discussion.

The most important task in treating dissociation in the mid-phase is further development of sufficient trust and high emphatic capacity. This task includes release of encapsulated, dissociative state by removing maladaptive ego-defences and insufficient information processing of the original traumatic experience, to facilitate the hierarchical integration of disintegrated parts of the personality, identity configuration, and dimensions of the self. When these interrelated processes of integration take adaptive stage, there is a natural and autonomic ability for the changes from the previously maladaptive affective-cognitive modalities of the functioning to an adaptive and functional self. It may be the case that knowledge of the transformative processes into positive, optimal state of the personality functioning is the archetypal expression of human striving towards unity, integration, individuation, and self-actualisation (Wilson, 2006).

van der Kolk et al. (1996) suggested that dissociated imprints of memory sequences are retrieved as sensory fragments that have no connection or wholeness. Such dissociated fragments should be joined by therapy as a coherent narrative memory of the traumatic experience. However, it is essential to avoid reconstruction of the traumatic experience based on the memory fragments, feelings, and fragmented perceptions. Initially, the incomplete and fragmented memory sequences may give wrong assumptions of the trauma patient's experience. Working on dissociation, the therapist faces variations of memory recall from time to time, more or less complete, that reflects defensive influences. Rosen (2004) stated that if dissociation involves compartmentalisation and subsequent avoidance of memories during a stressful experience, then rehearsal of memories should be effectively abolished.

Traumatised individuals with dissociation show chronic fears and anxiety, self-perception of poor physical and mental health, stress on important personal relationships, and a general sense of demoralisation and suicidality. Subjective perception of a life threat, perceived potential for physical violence, experience of extreme fear over the extended period of time and attribution of personal helplessness are all contributing factors which lead to many severely traumatised individuals in developing dissociation. Zlotnick et al. (1999) found relationship between childhood sexual abuse and symptoms of hostility, somatisation, dissociation, depersonalisation, alexithymia, social dysfunction, maladaptive schemas, self-destruction, and adult victimisation. Horowitz & Zilberg (1983) suggest that catastrophic events contain internal and external information—most of them cannot be incorporated into the individual's ordinary cognitive schemas because they are outside the realm of normal human experience. As this information cannot be integrated within the self, it is kept out of conscious awareness, and remains in its unprocessed active form.

Further work on dissociation focuses on the integration of disintegrated parts of the patient's personality into a cohesive whole and more cooperation among the parts of the personality. Two characteristics of trauma experiencing should be taken into account in achieving these goals: (a) most patients assume that a situation is safe in the absence of information signalling the danger; however, they never had enough safety signals to ensure that no danger exists and hence they are always alert, and (b) some patients experience anxiety and discomfort at a high negative valence, so they are more likely to avoid situations that exacerbate their anxiety. The treatment also includes reassurance that each part belongs to the entire sense of self and aliveness/vitality. The dissociative parts of personality can be activated by various stimuli which often are not under patient's full control. This may lead to maladaptive changes in the patient's basic emotions, goals, and behaviour; this is a problematic perception-motor action (van der Hurt et al., 2006). The maladaptive changes then bind any capacity in feared avoidance to the inner conflicts attached to dissociative parts of personality contributing to further decrease in levels of adaptive functioning.

Overcoming fears of dissociative parts of personality require a high level of engagement not only from the patient but from the therapist as well. All interventions should be designed to promote synthesis of the divided personality into one united part as a whole ("wholeness"). Trauma patients are unable or reluctant to recognise essential distortions in their personality because they are afraid to realise how distorted their thinking is that they cannot trust even their own thoughts, and the own self in general. As a result, they avoid "remembering" what happened in the past blaming "amnestic state" for fragmented or limited recall of the traumatic memories. They tend to compromise their senseless existence, their aliveness or togetherness, spontaneity, and individuality. Traumatised patients may become exhausted in their struggle against the self-destructive urges and thoughts driven by the inner conflicts. The therapy should promote adaptive mental and behavioural actions that will help the personality to function as a whole system with interrelated and interconnected functional parts.

### 2.3 The Final Phase of Treatment: Self-Conception, Enhancing Daily Living, Relapse Prevention

Goals in therapy should always be patient-directed, no matter how well trained and skilled the therapist is or, how extensively he may desire to "reconstruct" the patient's personality. In the final phase of treatment, therapeutic focus shifts to self-development, adaptations to normal life, and relationships. Although the previous two phases reduce symptoms and resolve dissociation and traumatic memories, the patient's full engagement in living is not achieved if the final phase is not accomplished. Trauma patients who are more able to construct the meaningful and realistic attitudes in the wake of the traumas are more successful in overcoming their traumatic experience. The remaining trauma-related beliefs and cognitive distortions related to the trauma are both addressed in the final phase of treatment.

Therapy is not a linear process, and frequently during the final phase, new memories or previously unidentified fragments of the memory may arise, perhaps due to the patient's increased integrative capacity that enables control of previously dissociated memories (Steele et al., 2005). It is not surprise that, after two successful phases of treatment, the patient may feel satisfied with the progress and conclude that a further therapy is not necessary. This fact has confounded many therapists. However, the disintegrative forces within the personality may be so strong as to threaten to break apart all adaptive self-structures if treatment stops prematurely. The trauma patient has an insufficient level of mental energy to integrate the traumatic past, and the levels of present functioning are still influenced by the horrors of the past. Free from the traumatic memories, the patient enters into the final phase of treatment with a requirement for more adaptive actions.

The final phase of treatment is a period when the haunted self should be finally restored to its pre-trauma levels of the self-continuity and self-cohesion. With increased integrative capacity, the trauma patient is able to better tolerate arousal, and he is ready for new connections to overcome fears of daily life, evaluate, take appropriate risks, and explore the changes of the divided personality. In the final phase of treatment, the patient begins to develop other neglected areas of personality and functioning such as professional and occupational needs or social belonging. The patient's changes in cognitive

distortions and corresponding physical tendencies are in focus alongside with establishing new or repair old relatedness. It is also evidenced that trauma patients are keen to sustain engagement in activities they found meaningful and pleasurable.

As the trauma shatters all structure of the self and its coherence and continuity, the therapy is faced with a question of how to help trauma patient to transform such powerful and life-threatening experience into a positive way. During the final phase of treatment, the therapy provides helpful structures as the patient practices new interpersonal and intrapsychic patterns, moving from a baseline of friendliness towards the self and others that include degrees of enmeshment and independency. In addition, it is a good balance between focus on self and focus on others. Thus, the transformation process that occurs in the nature of trauma results in an integrated and reinvented self with the whole structure from dissociated and disconnected parts, one that is more grounded, centered, and connected to its values. The self then becomes functional and higher state of the consciousness less impacted and parted by the inner conflicts and their drives.

The transformation of self will influence not only therapeutic framework (in content of traumatised self-interpretation), but also the therapist's general attitudes towards achieving the desired goals—the patient's entire recovery from the trauma. The point of view taken with regard to such seemingly focused target is how much trauma patient still feels helpless and dysfunctional. With the significantly improved functioning of the self-structure and being powerful with control of the inner conflicts, the question is whether the trauma patient is himself—or whether the self will remain always in some stage of depletion and division. In principle, the cohesive structure of the patient's personality tends to emerge optimally in a new environment. Having developed in collaboration and insight, the patient is able to review specific current relatedness in the light of input, response, and impact on the self. After recognising these connections, the patient anticipates the needs to block eventual repetition of the past patterns.

The final phase of therapy supports patient's self-discovery in (a) accepting what it was and what it is and moving forward, and (b) making mindful and benevolent choices. Self-discovery activities mostly focus on maintaining the motivation to move beyond the traumatic past. This phase of treatment to help the self-management is based on (a) identifying and practicing new, constructive patterns, and (b) resisting the wish to go back to old ways of management influenced by the inner impulses and traumatic past. However, the patient may express some "fear of newness and progress achieved" which indicates uncomfortable feeling of "newness" due to accustom loss of habitual ways that he practiced for so long.

The traumatised individual's major maladaptive assumption about others is often centred around the acceptance, competence, and control which determine the patient's sense of vulnerability of acceptance by others. Many fears of new relatedness might be better understood when the patient looks at the standpoint of these three issues and responses received from others. The fear of relatedness may be a result of fear that other people will reject the patient to get close or that others will control the patient, or that he is not able to reach their expectations, or that they might demand standards of behaviour and achievements. While transforming the patient's relatedness, the therapy should change or modify the underlying beliefs that predispose the patient to fear and anxiety of relatedness. In the process of collecting negative thoughts related to the expectations, the therapist intends to change the patient's views of the world. Therapy uses a deductive method which starts exploring patient's feelings and behaviour, and then moves to the automatic thoughts and to the assumptions behind the thoughts, and finally arrives at the patient's major concerns (Beck et al., 2005).

The therapy uses different methods to identify patient's negative assumptions in an attempt to reduce tension and the influence of maladaptive thoughts, emotions, and behaviour. It is aimed to achieve new coping strategies that will be outside the influence of the inner conflict drives, divided, and split personality. The therapy is focused on modifying and reformulating assumptions to find how they may fit to the adaptive relatedness. This can also be done by using *imagery exposure* as a method to train the patient to accustom himself to demands from the external world (Zepinic, 2008). For example, the therapist asks the patient to close his eyes and picture the pre-trauma memories and implement them in "*here-and-now*" environment.

Therapist needs to give encouragement to the patient to recall an experience in which pleasant relationships with others had dominated. It is almost common that the patient is able to have a vivid image of some positive relationships with others that strictly can be imagined to the present time. The patient is asked to concentrate on one which could best recall and which had significant influence on relatedness. Then, the therapist and patient work together on imagined pre-trauma relatedness, putting together strategies for the present time in a meaningful way (Zepinic, 2011, 2016). The patient is then asked to release feelings, thoughts, and body sensations associated with the early experienced relatedness and compare them with what he is experiencing at the present time. This procedure helps the patient to see how traumatic memories from the past create problems in the patient's present relatedness and the way to future happiness. Most patients succeed with the imagination of the previous relatedness in identifying feelings and contents of the feared present problems in forming new relatedness.

The patient's assumptions towards others are usually identifiable because he repeats the same patterns all the time. Further, his assumptions usually have a long history of existence and are resistant to change. To be effective, the therapist has to address the basic issues of relatedness which are easier to correct and which are less influenced by maladaptive thoughts and emotions.

The core concern of the traumatised patient regarding acceptance by others is that he will be rejected in some way by them. The development of disbelief dates back to the time of trauma when the patient had been overpowered, rejected, defeated, helpless, inferior, and pressured. In post-trauma time, he has a stigma or flaw that makes him unacceptable to the others. The patient may use a variety of strategies to get others to accept and love him unconditionally, but he is often terrified of rejection. He wants to please others and, because he feels unacceptable, he has been terrified of being alone and constantly seeks attachment and relatedness. The patient may exaggerate the extent and significance of social acceptance or rejection. Because the others opinions directly affect self-values, the patient is highly dependent on feedback from others and continue checks the possibility of acceptance. In case he receives positive feedback from others, the patient becomes more confident and generally performs better (Beck et al., 2005; Courtois & Ford, 2009; Ford et al., 2005). However, in the event of others rejecting him, his confidence goes down and performance deteriorates.

The integration does not occur automatically during the final phase of treatment and regression, which is an exact repetition of the pre-treatment comorbid condition with overwhelming feelings, projective mechanisms, and loss of the relatedness and self-continuity, may occur. These regressive episodes, however, cannot last as it was before the treatment or have a similar influential impact on the trauma 'personality. The trauma patient is now capable of working on the restoration of the disrupted condition easily and successfully. In case of regressive episode, it is usually short-lasting and does not block posttraumatic growth or shift into an opposite site causing split-off of the patient's personality. The therapy process of reintegration and restoration of regressive material is much easier and more acceptable. The patient does not show resistance to the changes, nor fears and anxiety. In fact, the patient can shift rapidly from the regressive episodes into an integrated stage by (a) recognition of the dominant object relations to (b) the definition of self and object representation and their interchange in transference, and to (c) the integration of split-off dyads with the integration of the self-representation into an integrative self and integrated concept of others.

Integration into integrated concept is a conscious process that the patient cherished with the therapist's support and confident therapeutic relationship. The patient comes into the final phase of treatment becoming more capable, relieved, valuable, affectionate, hopeful, relaxed, and courageous. It is expected that some "residual" sequences of trauma will be sufficiently resolved completely and that the patient's pattern of "acting out" is under control. However, the patient should be aware that "acting out" behaviour is a significant risk for the regression or relapse of condition. The crisis may occur in the event of some pressure, internal or external, which unbalances the personality system and the patient's learnt coping systems are unable to restore the homeostasis. Such crisis and "acting out" should be closely observed as restoration of the equilibrium is quite important.

Prevention of the "acting out" behaviour should focus on narratives about the doubtful feelings and the patient's strength and ability to cope with life situations. A viable recognition of reality should be developed and replaced with often intense and unrealistic initial fusion, which is driven by the patient's desperate or premature needs and hopes. It is also needed to explore the patient's personality system to tolerate stressful situation and the steps needed to be taken to avoid the crisis. The patient needs to be taught that the difficulties out of therapy may have a painful impact on the therapy progress and patient's recovery. Highly disorganised patients with broken relationships and lost faith in the outer world may not be able to find internal resources to cope with the crisis without support. They cannot regain self-control and may experience significant anxiety and fears that therapy progress has deteriorated.

Any crisis that is an aftermath of the patient's distressing behaviour demands a great availability and involvement of the therapist. In resolving this issue, the therapist should gather as much information as possible about the precipitating circumstances of the crisis and the patient's response. There is no doubt that self-containment can be under test and requires self-restrain, however, if the self-containment fails, the patient needs external containment which, in essence, the therapy provides. The self-containment is a process of holding back the full expression of emotions and enables the patient of full expression of emotion (Allan, 2006; Ulman & Brothers, 1988). The internal containment stems from compassionate relationship with own self and the capacity to mentalise various forms of the self-regulations. External containment stems from supportive relationships and secure attachments which the therapeutic alliance provides. The final phase of treatment focuses more on internal containment (self-containment) and less on external containment.

As has often been said, planning for the ending therapy should occur from the beginning of the treatment. Practically, it is in the therapeutic plan to achieve reasonable healing and recovery, and to accomplish therapeutic goals so that therapy can be ended. At the end of the therapy, we proposed that the treatment rests on three fundamental assumptions for the patient: the world

is meaningful, the world is benevolent, and the self is worthy.

## CONCLUSION

The Dynamic Therapy model has been developed upon emphasises that there is a complex process in interactions between different phenomenological components of the severe trauma and that there is a variety of the ways in which etiological factors can contribute to the onset of the complex trauma syndrome. The syndrome itself is a complex clinical presentation which cannot be resolve using standard recommended CBT or other stress-oriented therapies. We accentuated the main principles and targets in treating complex trauma syndrome: (a) trauma symptoms reduction and stabilisation, (b) processing traumatic memories and emotions, and (c) life integration after the trauma processing. These three tasks are a main concept of the Dynamic Therapy model, improving not only the *efficacy* but also the *effectiveness* of psychological intervention. The model is a goal-directed phased treatment towards the restoration of a disrupted sense of self that affects the inner and the outer world of the traumatised individual.

The Dynamic Therapy model implements three main areas of the posttraumatic growth and recovery: (a) restoration of a form of relatedness ("*Interconnectivity*"), (b) restoration of a sense of aliveness/vitality ("*Dynamism*"), and (c) restoration of an awareness of the self and the inner events ("*Insight*"). The model is individualised (the therapy is designed to specific problems in a given patient) and tailored to unique needs of individual patients, but it also takes into account their underlying commonalities, such as the integrative deficiencies, dissociation, trauma memory system, and the trauma impact upon the structure of the self (Zepinic, 2011). Changing how they feel, think, and act alongside with rebuilding self-acceptance are main therapy goals. Accepting their strengths as well as their weaknesses without a sense of shame or embarrassment are also focused goals in therapy.

The principles of restoring human intra and interpersonal relatedness, self-cohesion and continuity of traumatised individual remain a central focus on the recovery process. In the past three decades the search for an effective and specific treatment for the complex trauma syndrome has been intensified. New treatment methods have been developed by passionate clinicians who tried to find an answer for such horrible human suffering. Many researchers have revealed the efficacy of innovative treatment techniques and treatment outcomes, however, there is no consensus and data to indicate which therapy approach could be specifically employed for full recovery of the complex trauma syndrome. Even worse, within this common problem is the wisdom of the majority severe trauma victims worldwide who have never received formal treatment of any kind (Zepinic, 2010). In the study (Zepinic et al., 2012) of 845 refugees from the Balkans who settled in Germany, Italy, and the United Kingdom it was reported that 46.7% who reported symptoms of PTSD ten years after the war have never been treated for their trauma symptoms.

Although severe trauma of any kind produces chronic disturbances or may, at times, remain fairly untreatable, the therapists must not give up dealing with such a horrible condition. The trauma has been a process that grew up by its own momentum, that with its ruthless logic of its own envelopes more and more becomes a problem of our time. It is a process that breeds loss of trust and faith, loss of human values, the tyranny that causes self-hate and self-contempt, and an alienation from the self. We must be clear about the seriousness of this tyranny and our involvement in order to guard against destruction imposed upon the trauma victims and provide an effective treatment.

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