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Four-Phased Dynamic Therapy Model in Treating Trauma-Induced Dissociation

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Abstract

Traumatic memories are highly emotional, life-altering events that would appear to have the best chance of persisting into the entire life. In complex trauma syndrome, they are usually endless causing often dissociative phenomena—the alterations in one's consciousness. Thus, traumatic memories may cause a constant feeling of intense fears, helplessness, loss of control, affliction of the powerlessness, and threat of annihilation. Traumatised person usually reports loss of the basic sense of self and bodily integrity. The principle of healing is empowerment of the patient's ability to re-create the basic capacities for trust, autonomy, competence, identity, and intimacy. The dissociative PTSD subtype is characterised by overmodulation of the affects—predominance of reexperiencing and hyperarousal symptoms with "hidden" and deeply unconscious traumatic memories. Although there are many ways to conceptualise dissociation, in this article we have emphasised the trauma-induced dissociation that involves detachment from the overwhelming emotional content of the experience during and in the aftermath of trauma experience. It has been hypothesised that such experiences elicit dissociation, promoting discontinuity of one's conscious experience and narrative memory. Four-phased patient oriented Dynamic Therapy model in treating trauma-induced dissociation targets three main goals: 1) restoration of a form of the relatedness (*Interconnectivity*), 2) restoration of a sense of the aliveness/vitality (*Dynamism*), and 3) restoration of an awareness of the self and inner events (*Insight*).

Keywords

Awareness, Cognitive Restructuring, Identity, Inner Conflicts, Self-at-Worst, Traumatic Memories, Unconsciousness

1. Introduction

Traumatic memories are an imprint of traumatic event in which the settings and

measures are out of the individual's ability to control; they are qualitatively different from normal narrative memory and include sensory, affective, motor reliving experience, and the behavioural re-enactments (Herman, 1992; Van der Kolk et al., 1986; Zepinic, 2011). It is common that the traumatic memories have been provoked by negative, or repugnant intrusive thoughts which may take form of ideas, images, and urges which persist and prevail over (*unconsciousness*), despite the patient's intention to control or to neutralise them (*consciousness*). The patient's traumatic system (emotions, cognition, sense of self, and tendencies to respond) is fulfilled with a stored unconscious and triggered traumatic material controlled by inner conflict drives (Van der Hart et al., 2006; Zepinic, 2012, 2016). Well-known French neurologist, Jean Martin Charcot, described traumatic memories as the "parasite of the mind" (Charcot, 1887).

Experiencing severe trauma, people are exposed to the "vehement emotions" and their mind may not be able to match what is going on with existing cognitive schemata. As an aftermath, the memories of traumatic experience cannot fully be integrated into one's personal awareness, and indeed they are split off (dissociated) from conscious awareness and one's control. Thus, the comprehensive formulation of the effects of trauma on the mind is based on the notion that failure to integrate traumatic memories as narrative memory, due to extreme emotional arousal, results in development of the complex PTSD symptoms (Zepinic, 2011).

In severe cases, this may cause the "phobia of traumatic memories" which may prevent integration of the traumatic event(s), and splits these traumatic memories off from the ordinary consciousness. Thus, the traumatic memories had become integrated (fixed) into unconsciousness and cannot be liquidated nor translated into a personal narrative. As such, they continue to intrude patient as terrifying perceptions, obsessional preoccupations, and somatic re-experiencing. Subsequently, the traumatised individuals react to reminders of the trauma experience with responses that had been relevant to the original trauma with no adaptive value. Upon exposure to the reminder of the trauma, patients experience the somatosensory representations of the trauma. As such, traumatic memories cannot be integrated into the narrative memory (personal awareness); they become attached or fixated to the trauma in the past.

Failure to integrate traumatic memories into narrative memory, results in an inability to assimilate new experience as well. Traumatic memories stop patient, at certain point, of integration or assimilation of any new material. Janet (1925) proposed that the efforts to keep the fragmented traumatic memories out of one's conscious awareness eroded the psychological energy of the traumatised individuals. This may interfere their capacity to engage in focused and creative actions, and their ability to learn from experience (Van der Kolk et al., 1986; Zepinic, 2011).

Traumatic syndrome comprises an altered conception of the self in relation to the world, based on being fixated on the trauma experience and having an atypical dream life, with chronic irritability, startle reactions, and explosive ag-

gressive reactions, or no reactions at all (Zepinic, 2016). This condition is a result of the fact that traumatised self dedicates itself to the specific acts of ensuring the security of the organism, and trying to protect itself against painful recollection of the trauma. Patient is "stuck" in the trauma ("*there-and-then*") circumstances and cannot activate and engage in current circumstances ("*here-and-now*"); whatever activity he engages it is with a certain stereotyped futility. This sense of futility often overwhelms patient—he became withdrawn and detached.

Intrusive thoughts about trauma prevent patient to think positively or to make an analytic answer about relations between a trigger and intrusive thoughts (Herman, 1992; Wang et al., 2009). Because of the repeated behaviour induced by intrusive thoughts, it is common that traumatised individuals are being misdiagnosed of having paranoid or delusional obsessiveness which, in fact, implies that thoughts about trauma are persistent with no patient's awareness about them. However, these thoughts fix patient into the traumatic environment and induce patient's behaviour ("*survival skills*") as if the original trauma occurs at the present time. The therapeutic aims should not be to eliminate intrusive thoughts but helping patient to: 1) consider intrusive thoughts as senseless mental noise rather than sufficient threatening, and 2) learn to manage acceptable levels of the risk, uncertainty, and doubt associated with the intrusive thoughts (Zepinic, 2018).

Evoked by the trigger, the traumatic memories represent an intrusive return of the unassimilated (non-coded) material in fragmented, sensory, affective, and motoric form. We emphasised four features that distinguish traumatic memories from a normal narrative memory:

1) Traumatic memories are composed of the images, sensations and affective state; narrative memories are semantic and symbolic;

2) Traumatic memories are inflexible and unstable (invariant) over time; narrative memory serves one's social and adaptive functions;

3) Traumatic memories cannot be evoked but elicited under specific circumstances (triggers) of the original event; narrative memory is assessible without trigger; and

4) Traumatic memories take time to be remembered; narrative memory is a common response on social demands.

As an aftermath of the traumatic memories, the traumatised individual may suffer self-discontinuity—the trauma victim is flooded with intrusive memories of the trauma, as well as thoughts, images and dreams (nightmares) with compounded levels of hyperarousal or flashbacks (Cohen et al., 2011; Peng et al., 2009; Van der Hart et al., 2006; Van der Kolk & Fisler, 1995; Wilson, 2006; Zepinic, 2016). When clinical symptoms, such as the flashbacks, nightmares or other sleep problems, difficulty concentrating, and emotional liability, are mild and have been present for more than four weeks after traumatic event(s), the early psychological intervention in form of debriefing has no effect in preventing

PTSD, or even simple debriefing may in addition be harmful (Ahmadizadeh et al., 2013; Gist & Devilly, 2002).

Traumatic memories can be generalised and triggered by a large array of experiences—anything that reminds of original trauma can be experienced as a threat, regardless of its origin. This is because of the traumatised individual's fixation on the trauma what causes to react as if the original traumatic experience is still in existence and engages protective devices which failed on the original occasion. This means, in effect, that his conception of the outer world and his conception of himself has been altered and run by the inner conflict drives.

One of the essential issues in treating traumatic memories is to bring them into patient's awareness (Courtois & Ford, 2009; Ehlers & Clark, 2000; Herman, 1992; Van der Hart et al., 2006; Van der Kolk et al., 1986; Zepinic, 2018). Trauma is unpredictable experience which may change all structures of the normally desired personality wholeness and functioning. The horrible traumatic memories are like an active volcano—can erupt at any time causing unpredictable consequences and damages on the trauma victim's personality. As such, the traumatised personality is an iceberg for the clinicians—the iceberg which cannot be seen in whole (Zepinic, 2001).

2. Defining Trauma-Induced Dissociation

Although definition of "dissociation" has varied, it is generally centered on the assumption that dissociation involves a lack of integration of aspects of information processing that would typically be connected. Dissociation involves detachment from the overwhelming emotional content of the experience during and in the immediate aftermath of trauma (Lanius et al., 2010). Dissociation is referred to as both a psychological outcome of trauma and a mechanism of trauma-related problems (e.g. memory, affects). Diagnostic system should facilitate reliable findings how much the trauma-induced dissociation changed or destroyed one's personality—the sense of self (its cohesion and continuity). Since the French psychologist Pierre Janet first wrote about the relationship between trauma and memory, it has been widely accepted that traumatic memories of stressful event(s) are an active and constructive process. He proposed that traumatic memories may cause a developmental arrest with a narrow and constricted consciousness (Janet, 1925). Janet was first clinician who articulated the basic principles of the dissociative phenomena based on observation of the alterations in one's consciousness. Also, he was one investigator to elucidate the adaptive nature of dissociation dealing with the acute/or chronic trauma.

Foundation of traumatic memory studies by Janet and his colleagues was lost to a period of neglect of dissociation and trauma. However, based on the Janet's basic principles of the trauma-induced dissociation, many clinicians of the modern traumatic stress studies (Courtois, Foa, Ford, Herman, Horowitz, Resick, Van der Kolk, Wilson, etc.) revive his work and findings. For example,

Myers (1940) described dissociative reactions to the combat exposure while introducing "*shell-shock*" syndrome among the combatants. He proposed that emotional disturbance alone was enough of an explanation for the trauma-induced dissociation rejecting a relationship between battle neurosis and an organic (molecular commutation) in the brain.

What each traumatised person remembers depends on existing schemata; once an event or particular bit of information is integrated into the existing schemas. However, accuracy of the memory is affected by emotional violence of the traumatic experience (Zepinic, 2009). Van der Hart and colleagues (2004) argued that dissociation is a lack of integration among psychobiological systems that constitute personality, and Putnam (1997) was of opinion that the dissociation is characterised by profound developmental differences in the integration of behaviour and in the acquisition of developmental competences and metacognitive functions. Extreme emotions and thoughts caused by trauma may cause on person to feel changeably different from time to time, and that it may see there is no consistent *me* or *myself.*

Even though dissociative symptoms are observed following exposure to psychological trauma which is complex in its nature, a number of studies of individuals experiencing danger or life threat have shown specific dissociative changes (peritraumatic dissociation), including alterations in time sense, perceptions, attentional focus, and awareness of pain among others. In addition, depersonalisation is often observed in a significant percentage of individuals facing acute life threat or severe danger for bodily harm. Information related to the traumatic experiences is often differently encoded in these altered states, resulting in decreased access to information about the trauma once the person returns to his baseline state (Lanius et al., 2010). This may give a sense of "compartmentalisation" of the trauma experience that lead to cognitive fragmentation or emotional detachment from the experience (dissociation). A chronic pattern of dissociation in response to reminders of the original trauma develops in persons who experience acute dissociative responses to psychological trauma.

Bremmen & Brett (1997) defined dissociation as an impairment of the normal integration of trauma thoughts, feelings, and experiences. Ford (2009) stated that the dissociation can be understood phenomenologically as a splitting of the self-awareness such that an individual experiences perceptions, feelings, thoughts, motives, and action as organised by a self that either is transiently absent (e.g., fugue states, loss of memory), alien (e.g., depersonalisation), altered (e.g., derealisation), or fundamentally altered as to seem to be distinct other selves (e.g., DID). When an individual experiences emotions and primary relations as extreme, unpredictable, and unmanageable, then this individual is likely to have a great difficulty in sustaining a consistent organised sense of self (Zepinic, 2012). Due to dissociation, traumatised individual may experience several *Selfs* or *Mes* which may be so different such even not belong to the same person or feeling that *Me* is a *stranger* to the own personality (*Self*).

We believe that trauma-induced dissociation is an integral part of one's overall comorbid condition rooted in the complex neurophysiological processes, including conditioned emotional reactions that processed the unconscious awareness of traumatic experience. In DSM-5 (APA, 2013), diagnostic criteria for PTSD require to specify whether the disorder is with dissociative symptoms. The criteria require whether, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1) Depersonalisation: Persistent or recurrent experience of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling of a sense of unreality of self or body or of time moving slowly).

2) Derealisation: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Chronic psychological, sexual, and physical trauma have been etiologically related to dissociation. Alterations in memory encoding and storage ensue, leading to fragmentation and compartmentalisation of memory and impairments in memory retrieval (Spiegal & Cardena, 1991). These findings have important implications for treatment of the trauma-induced dissociation, including the needs to assess patients with complex PTSD for their dissociative symptoms and to incorporate their treatment of dissociation into stage-oriented trauma treatment. Overtness or covertness of dissociative identity varies as a function of psychological motivation, level of stress, internal conflicts and dynamics, and emotional resilience. Sustained periods of dissociated identity may occur when stressful event(s) is severe and/or prolonged.

3. Observing Trauma-Induced Dissociation

Measuring dissociation requires thought about both the definition of dissociation and conditions under which it occurs. Among clinicians, it is an undisputed opinion that trauma-induced dissociation is pathological as opposed to alterations of consciousness normally distributed in the population. The vast majority of researches has focused on negative symptoms of trauma-induced dissociation, such as amnesia, loss of awareness, or loss of self-continuity and cohesion (Van der Hart et al., 2004). However, the clinicians are also of opinion that the dissociation also includes positive symptoms such as flashbacks and/or intrusions, and psychosomatic symptoms such as sensations and/or perceptions (Van der Hart et al., 2006; Zepinic, 2011).

Trauma-induced dissociation is related to discontinuation of experience that can affect any aspect of individual functioning. Patients with such condition may report the feeling that they have suddenly become depersonalised observers of their "own" body and mind, and actions, which they may feel powerless to stop (sense of "self at worst"). Also, such patients may report perceptions of voices (which are not schizophrenic-like delusions or hallucinations). In some cases,

voices are experienced as multiple, independent thought streams over which the individual experiences no control (Spiegal & Cardena, 1991; Van der Hart et al., 2006; Zepinic, 2016). Strong emotions, impulses, or other actions may suddenly emerge, without a sense of personal ownership or control (sense of agency). These emotions and impulses are frequently reported as ego-dystonic and puzzling. Patients may report that their bodies feel different, and alterations in sense of self and loss of personal agency.

Numerous researches have documented a correlation between dissociative symptoms and traumatic experience making that, in clinical literature, the term of "trauma-induced dissociation" became a commonly used. Generally, this describes that trauma is a causal factor in the development of dissociative symptoms. It is important to note an inherent difficulty in interpreting correlation data (considering self-report of trauma) in regard to the severity and complexity of the dissociative state. However, numerous researches of trauma survivors revealed that, indeed, dissociation is present as an aftermath of trauma experience. For example, Putnam & Trickett (1997) compared 77 sexually abused girls to 72 control girls in a longitudinal study of the psychological effects of sexual abuse. They found that the sexually abused girls had significantly elevated the dissociation scores in comparison with a control group.

However, there is no consensus among clinicians about how to conceptualise the relations between dissociation and the other symptoms of complex PTSD, as well as other trauma-related disorders. On the other hand, diverse symptoms of the complex PTSD and other trauma-related disorders may occur from the same traumatisation without dissociation. This implies needs to evaluate and formulate the level of intercorrelated dissociation and symptoms of complex PTSD, but also with other serious problems such as disruptions in relationship or attachment capacities.

Carlson and colleagues (2009) emphasised that disorganised attachment is also indication of the trauma-induced dissociation in complex PTSD. Clinical experience reveals that the severe traumatised individuals usually have a highly disorganised attachment (which is also a sign of their insecure attachment). Disorganised attachment occurs within a context of trauma survivor's loss of the trust and faith, and it indicates that the patient's detachment will then trigger *disorganised/disoriented* reactions towards the external world in post-trauma period. Thus, the dissociation is hypothesised to be more prominent in cases of attachment deficits or when the person cannot develop a secure attachment.

In some severely traumatised patients, it is evident that existing traumatic memories, alongside with the psychic dissociation, may produce various somatoform dissociation at the same time. Prolonged or repeated exposure to the traumatic event(s) may cause one's persistent re-experiences, persistent avoidance, and/or persistent hyperarousal to be dissociative in nature making the trauma disorder more complex having three or more dissociative symptoms including numbing, reduction in the awareness of surrounding, depersonalisation, derealisation, and dissociative amnesia.

Van der Hart et al. (1999) emphasised that posttraumatic amnesia is frequently associated with war neurosis in form of loss of sensory, loss for non-traumatic personal information, and perceptuomotor functions. Memory loss could be both anterograde and retrograde—it is common that severely traumatised individuals are unable to recall their name, family background or marital status. In short, they lost their identity (Van der Hart et al., 2006; Zepinic, 2009). Myers (1940) explained a case of total amnesia, following shell explosion:

> "A soldier was assessed three days after having been admitted into a field ambulance. He was unable to give his name, regiment, or number, and he could not be identified. He could remember being found on the outskirts of a village, but his military history and all events in his past including his childhood were a complete blank".

Myers (1940) regarded this as manifestations of the emotional personality, alternating with the apparently normal personality. When fighting scenes are vividly re-experienced by a trigger, the trauma victim is re-experiencing pseudo-fighting movements. However, when unconscious re-experiencing is over, the person appears normal personality with no fear nor any recollection of the alternate state, and immediately resumed expression of stigmata. A symptomatic transition could be readily recognised from partial to complex re-enactment, and symptoms through somnambulism to fugue underline extensive trauma induced amnesia. Dissociation can be so complex that manifestations of the trauma did not come into consciousness and recognition of the trauma event(s) could be considerable delayed. Traumatic memories remain latent and inactive, and trauma victim may appear to function normally until the trigger revokes traumatic memories.

Severely traumatised individuals usually lost their basic qualities—their capacity for an integration which unites a broad range of psychological, biological, and social phenomena within one (whole) personality. The stress experience causes a limit level of integration, such as actions and tendencies, as capacities cannot be coordinated and flexible to adjust one's disordered self to the environment (Zepinic, 2012). The traumatised individual is unable to adapt his/her self in creative and complex way, and determine tendencies and actions what a non-stressed self would integrate in a given moment or situation. As the self-organising system is affected, shattered, and insufficient, it cannot be integrated in undertaking implicit and explicit functions and mental contents.

Steel et al. (2009) stated that the trauma-induced dissociation is primarily an ongoing integrative deficit that results in a structural dissociation of the personality. Dissociated parts of the one's personality diminished the capacity to integrate ongoing processes into a coherent personality that allows the traumatised individual for adaptive functioning. Such traumatised integration is based on two main aspects: 1) synthesis of components of the experiences (e.g., sensations, perceptions, sense of self) within the given episode of the traumatic

event(s), and 2) synthesis of knowledge and functions across time of traumatic experiences into the shattered self (Zepinic, 2012). Depends how much division of the personality occurred during trauma, traumatised individuals are often unable to hold sufficient integration of the divided and disintegrated dissociative parts of the personality being incapable for actions, tendencies, or adaptation.

While elaborating trauma victim's dissociation, it is evident that the origins of it involve two insufficient integrations among dissociative parts of the personality: 1) the emotional part of personality, and 2) the apparently normal part of personality. The emotional part of the personality remains fixed in the traumatic experience, with its vivid and terrifying sensorymotor memories of the traumatic event(s) causing vehement emotions which are fulfilled with fear, helplessness, horror, anger, and sadness that overwhelm the one's capacity for integration and organisation. The apparently normal part of the personality phobically reminds the traumatised personality of traumatic experience. When trauma victims speak about their traumatic event(s) it is distant without a sense of personal ownership of the experience (insufficient personification). Apparently normal personality has integrated neither the traumatic memory, nor the normal system, and often manifests a range of the negative dissociative symptoms as partial or complete amnesia for the traumatic event(s).

Trauma-induced dissociation may appear in form of: 1) dissociative identity disorder, 2) dissociative amnesia, 3) dissociative fugue, 4) depersonalisation and/or derealisation (Zepinic, 2012). Defining feature of dissociative identity is the presence of two or more distinct personality states or an experience of possession (Criterion A of DSM-5). The overtness or covertness of these personality states, varies as a function of psychological motivation, level of stress experience, culture, internal conflicts and dynamics, and emotional resilience (APA, 2013). The most common disruption of the identity (self-cohesion and continuity) appears as a result of prolonged or repeated trauma causing an alternate personality state: 1) sudden alterations or discontinuities in sense of self, and 2) recurrent dissociative memory (Zepinic, 2016).

Alternate personality state may cause discontinuities of experience that can impact any aspect of an individual's functioning. Individuals with dissociative identity may report feeling that they have suddenly become depersonalised observers of their "own" body, thoughts, speech and actions, which they may feel powerless to stop (uncontrolled self). They may also report perceptions of the voices or senses, which are different from the delusions and/or hallucinations in schizophrenia. Alterations in sense of self and loss of personal agency may be accompanied by a feeling that these attitudes, emotions, and behaviours—even one's body—are "*not mine*" and/or are "*not under my control*". Some individuals may also experience transient psychotic phenomena or episodes which are involuntary and time-limited. Dissociated identity, as an overwhelming experience, may generate problems in memory, concentration, attachment, and traumatic play with overlaps and interference among mental states—discontinuities of experience.

Dissociative amnesia is a sudden inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness and it is not associated with an organic mental disorder. The dissociative amnesia involves reversible memory impairment in which memories of personal experience cannot be retrieved in a narrative form due to partial or no retain in consciousness. It should be pointed out that dissociative amnesia is centred on traumatic events and that the extent and completeness often vary from day to day, but there is a persistent common core that cannot be recalled in the waking state. For the diagnostic purposes, it requires that: 1) amnesia, either partial or complete, for recent events that are of a traumatic nature, and 2) absence of organic brain disorder, excessive fatigue, or intoxication.

DSM-5 (APA, 2013) defines that dissociative amnesia manifests in three primary ways: 1) gaps in remote memory of personal life events (e.g., periods of childhood or adolescence; some important life events, such as death of loved one); 2) lapses in dependable memory (e.g., of what happened today, or well-learned skills such as how to do usual job, use a computer, read, drive); and 3) discovery of evidence of everyday actions and tasks that do not recollect (e.g., finding unexplained objects in own possession; finding perplexing writings or drawings created; discovering unexplained injuries; "coming to" in the midst of doing something). Dissociative amnesia differs from the permanent amnesias due to neurobiological damage or toxicity that prevent memory storage or retrieval in that it is always potentially reversible because the memory has been successfully stored (APA, 2013).

However, despite the evidently dissociated identity, the patient's disordered "awareness" denies or minimise apparent amnesic symptoms. While treating dissociative identity, it is important to focus on a fact that dissociative identity is present recurrently, unwanted and involuntary, which causes significant distress or impairment, and it is not a normal part of a broadly accepted cultural or religious practice. Many patients with dissociative identity report dissociative flashbacks during which they undergo a sensory reliving of a traumatic experience as though it were occurring in the present, often with a change of identity, partial or complete loss of current reality during the flashback, and a subsequent amnesia for the content of the flashback (Bremmen & Brett, 1997; Courtois & Ford, 2009; Zepinic, 2012, 2016).

Dissociative fugue usually resolves into the amnesias: the person emerges from fugue and regains both memory and identity having amnesia during the fugue. For this reason, the dissociative fugue could be conceptualised as a variant of the dissociative amnesia but with more complex structure and a sequence of stages. Essential feature of dissociative fugue is sudden, unexpected travel away from home or one's customary place of daily activities, with inability to recall some or all of one's past. Thus, the person with dissociative fugue may report that he has suddenly found himself at the beach, at work, in a night-club, or somewhere at home (e.g., in the closet, on a bed or sofa, in the corner) with no memory how he/she came to be there. Those with trauma-induced dissociative

fugue may not be limited to stressful event(s), the dissociative fugue affects their everyday events as well.

Like any other dissociative state, dissociative fugue causes clinically significant impact upon one's functioning in all important areas. While describing patients with dissociative fugue, Janet (1925) observed that they are patients in full delirium (hypnotic state)—they travel around, talk to many people, they are preoccupied and dreamy, but they are still not recognised as mad people. The *altered personality* was created during the period of dissociative fugue, and it is suppressed after the person emerges from the fugue and resumes executive control of personality. Seen in this way, amnesia for the period of fugue occurs because it controls the original identity and memory has not been integrated. Integration would produce continuity of personality (identity), not alterations. Thus, the clinicians have a very rare opportunity to talk with *altered personality* during the fugue and usually observe and evaluate alterations of identity in the post-fugue state. Ross (2009) observed that fugue is not an undifferentiated period of time; a fugue is divided into two sub-stages, each with its own form of amnesia: 1) the stage of flight, and 2) the stage in the new location (that is characterised by amnesia for the period of flight).

The travel in a fugue state usually takes aimless wandering, but also often appears quite purposeful in using a public transport. An ordinary observer who is not familiar with mental disorder cannot notice anything unusual or strange apart that person communicates with a lot of people and the talk is unstoppable. The person may behave quite politely, servilely, and supports other passengers in any possible way. Travel may range from a short trip to a long journey (e.g., weeks or months) to unknown places with some individuals crossing different countries and national borders and travelling thousands of miles without any other purpose but to travel.

During a fugue, individual may appear to be without any sign of psychopathology and generally does not attract specific attention. At some point, the individual is brought to clinical attention, usually because of showing amnesia for recent events or a lack of the awareness of personal identity (Zepinic, 2012). When person with the dissociative fugue returns to normal pre-fugue state, he does not have a memory for the events and what has happened during fugue state.

As dissociative fugue by DSM-5 (APA, 2013) cannot be diagnosed without predominant disturbance—experience *travel away from home,* it is, in clinical practice, often difficult to make distinction between a generalised dissociative amnesia and fugue. It is common that the trauma survivor with dissociative fugue develops temporarily a new identity secondary to the primary problem. The assumptions of new identity (partial or complete), however may more severe impact upon one's personality than dissociative fugue itself. Clinically speaking, the dissociative fugue is a dual personality in which the *host personality* is suppressed and then re-emerged.

The suppression occurs during the fugue and if such *altered personality* is

created during this period it is suppressed from the executive activity. However, there is no consensus among the clinicians in regard to the continuum existence of the *altered personality* after the returning to the *primary personality.* Also, the memory as well as actions, and feelings of the fugue (*altered*) personality are not integrated into *primary personality,* so that the continuity between two personalities does not exist.

Individuals with dissociative fugue vary in their awareness and attitudes towards their amnesias and report not having control over own actions. They could not explain what "outside person" overtook control of the behaviour that individual acts in a distinctly different and uncontrolled manner. For them, it seems that some "ghost" acting in their behalf and controls the patient's behaviour, thoughts, or emotions. Or an individual may be "taken over" by a "demon" resulting in profound impairment in all areas of functioning, and demanding that the individual follows the identity alterations.

DSM-5 (APA, 2013) in its diagnostic criteria for PTSD recognised that, in response to the traumatic event, the trauma victim may experience persistent or recurrent symptoms of depersonalisation, derealisation, or both. Episodes of depersonalisation are characterised by a feeling of unreality or detachment from, or unfamiliarity with, one's whole self or from aspects of the self (APA, 2013). The individual with trauma-induced depersonalisation may feel detached from his entire being (e.g., "*I am no-one*", "*I have no self*"). He may also feel subjectively detached from aspects of the self, including feelings (e.g., hypoemotionality: "*I know I have feelings but I don't feel them*"), thoughts (e.g., "*My thoughts don't feel like my own*", "*My head is filled with cotton*"), whole body or body parts, or perceptions (e.g., touch, proprioception, hunger, thirst, libido).

Trauma victims with depersonalisation may experience a diminished sense of agency (e.g., feeling robotic, like an automaton; lacking control over speech or movements). According to DSM-5 criteria, the depersonalisation experience can sometimes be one of a split self, with one part observing and one participating, known as an "out-of-body experience" in its most extreme form (APA, 2013; Zepinic, 2016). DSM-5 defines that the unitary symptom of depersonalisation consists of several symptom factors: anomalous body experiences (e.g., unreality of the self and perceptual alterations); emotional or physical numbing; and temporal distortions with anomalous subjective recall (APA, 2013).

Episodes of derealisation are characterised by a feeling of unreality or detachment from, or unfamiliarity with, the world, with individuals, inanimate objects, or all surroundings (APA, 2013). The trauma-induced derealisation may produce the patient's feelings that the world or surroundings are artificial, colourless, or lifeless, and it is common accompanied by subjective visual distortions (different from visual hallucinations in schizophrenia), such as blurriness, heightened acuity, widened or narrowed visual field, two-dimensionality or flatness, exaggerated three-dimensionality, or altered distance or size of the objects (macropsia or micropsia). Auditory distortions may also appear, whereby voices or sounds that could be muted or heightened.

In clinical practice, patients who experienced depersonalisation and/or derealisation have difficulties to report their symptoms and may think they are "going crazy" or "being totally mad". It is quite common that patients cannot connect present dissociation with the past trauma experience but rather with eventual irreversible brain damage. Patients have a fear of the organic causes for their dissociation and often experience subjectively altered sense of time, as well as a subjectively difficulties in vividly recalling past memories and owning them as personal and emotional.

These feelings are often accompanied by vague somatic symptoms, such as head fullness, tingling, or light headedness which are not neurological in its nature, but psychological. Patients usually spent a lot of medical tests and investigations in order to find out a cause for psychosomatic symptoms but test results do not provide "satisfactory" answer making patients to suffer an extreme rumination or obsessional preoccupation (e.g., constantly obsessed what is really reason for symptoms, or checking their perceptions to determine whether they "appear real"). Individuals with derealisation have been found to have physiological hyporeactivity to the emotional stimuli.

There is a clear association between the disorder (depersonalisation, derealisation) and trauma experience. In particular, the emotional abuse (e.g., severe torture, interrogation, brutal rape, domestic violence and physical abuse) is the most strongly and consistently associated with the disorder. In essence, the most common proximal precipitants of the depersonalisation and derealisation are severe interpersonal stress (e.g., combat related, war imprisonment, torture) which is highly distressing and is related with major morbidity.

The affectively and robotic demeanour that these individuals often demonstrate may appear incongruent with the extreme emotional pain reported by those with the disorder (Courtois & Ford, 2009; Wilson, 2006; Zepinic 2018). Impairment is often experienced in both the interpersonal and the occupational spheres, largely due to the patient's hypoemotionality with others, subjective difficulty in focusing and retaining information, and a general sense of disconnectedness from life.

4. Treatment Strategy for Trauma-Induced Dissociation

The current standard of care with regard to the treatment of trauma-induced dissociation entails, among other things, the application of a phase-oriented treatment model (Allen, 2005; Courtois & Ford, 2009; Herman, 1992; Van der Hart et al., 2006; Wilson, 2006; Zepinic, 2009, 2011, 2018). Phase-oriented trauma treatment has its origin in the pioneering work of Janet (1925) who describes three phases in the overall treatment: 1) stabilisation and symptom reduction; 2) treatment of traumatic memories; and 3) personality reintegration and rehabilitation. However, in clinical practice, it is common doubt whether the patient with severely trauma-induced dissociation and complex dissociative disorder will be capable of integrating the traumatic past (Van der Hart & Boon,

1997).

There are several therapy concepts in treating dissociation since Janet for the first time described disintegration of the self due to one's chronic traumatisation. In forming our approach to provide therapy for trauma-induced dissociation, we should take into account definition of dissociation and its impact on one's personality dysfunctions. To do this, it is necessary to systematically examine a series of dissociative reactions over a number of therapy sessions. Based on over ten years of the clinical experience working with severely traumatised patients at our PsychClinic P/L, we have developed a four-phase model of the *Dynamic Therapy*[1] in treating complex PTSD and other stress-related disorders. The main concept of this model is based on treating goals in the complex PTSD: 1) alleviating or removing symptoms; 2) adjusting the patient's life situation so that it imposes a minimal burden; 3) inducing to change disorganising attitudes and life goals; and 4) investigating what conflicts are at the bottom of the patient's difficulty in dealing with them on various corrective levels.

Because of its complexity, dissociation is very difficult to be treated but phase-oriented approach is recommended in doing with such problems (Janet, 1925; Van der Hart et al., 2006; Zepinic, 2011, 2018).

The *Dynamic Therapy* model is a multimodal system and originally cast as the cognitive-behavioural-analytical-dynamic approach with three main therapy targeted goals (Zepinic, 2011, 2018):

1) The restoration of a form of relatedness (*Interconnectivity*);

2) The restoration of a sense of aliveness/vitality (*Dynamism*); and

3) The restoration of an awareness of self and inner events (*Insight*).

The *Dynamic Therapy* model concept is aimed to integrate basic personality principles from 1) stabilisation and symptoms reduction through 2) integration of dissociative parts of personality, and then towards 3) personality integration to a degree in which the patient has success in major areas of a normal life free of anxiety and fears.

4.1. Early Phase of Therapy

Under the *Dynamic Therapy* model, therapy on dissociation starts in the early phase of treatment (*Impulse containment; Engagement; Safety; Stabilisation*) and has continued throughout the entire treatment. We emphasised that trauma-induced dissociation is a multiple and basic aspect of traumatised personality, rather than as a rare phenomenon. Putnam (1989) stated that, while treating over 70 combat veterans, they reported having experienced of an extreme detachment and depersonalisation during moments when they through 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, such as intern-

[1]The concept and detailed description of four-phased model is written in the book *Hidden Scars: Understanding and Treating Complex Trauma*, published by Xlibris in 2011.

ment of the war prisons or concentration camps.

As discussed above, the patients with a complex trauma syndrome may experience the exacerbation of the dissociative symptoms following discovery of one or more alterations of personality. The disturbances in a sense of self-continuity can cause complete amnesia for self-referential information which can give a clue about pre-trauma details such as vulnerability to stress. The second principle of dissociation will be disturbances in the trauma survivor's memory that may result in complex amnesia or memory fragmentation. These problems influence the patient's fragmented intra and interpersonal relationship, behaviour, and relatedness towards others.

Dissociation seen as a division of one's personality that causes disintegration into parts (dissociative parts of personality) requires therapy to target integration as a key point in restructuring damaged self. The process of reintegration requires the patient's self-awareness (consciousness), mental, and behavioural actions. From the model of trauma-induced dissociation, the treatment should emphasise three main principles: 1) to improve adaptive functioning; 2) expression of personality "*here-and-now*" than to the past; and 3) reconstruct capacities to apply difficulties rather than being directed by them (Zepinic, 2011).

In an attempt to improve adaptive functioning, the clinician introduces distinguishing means (e.g., processing trauma, identifying triggers of dissociative episodes). The therapy looks for ways of increasing the patient's capacity to remain attentive to the "*here-and-now*" time instead of "*there-and-then*", with exploration that identifies particulars such as the nature of dissociative symptoms experienced, how they impact daily functioning, or factors that exacerbate or ameliorate levels of dissociative symptomatology. Then, the patient is taught how to apply and cope with the difficulties, improve his capacities to deal with dissociation and associated problems rather than being directed by them. These adaptive living skills require new adaptive strategies and, because of the course of early phase of treatment, substantial therapeutic progress will occur and continue until finished treatment—termination phase of treatment (*Independency; Integration; Steps Forward*).

Severely traumatised individuals with dissociation usually have poor capacity to recognise experiencing affect and have difficulty in identifying and labelling their emotions. Because of that, the patient is caged by his strong emotions and may express relatively strange behaviour (impulsive or maladaptive), and damaged relatedness. As dissociated parts of the personality are not united in whole, it is common that the patient is totally unaware of some distorted sequences of his behaviour, relatedness, and/or emotions. In fact, the awareness is the presence of affect and, depending of intensity, severity, and type of the affect, the entire behaviour, cognitive functions, and attachment is regulated by these distorted affects.

Consequent to the direct impact by such affects, the patient behaves without ability of cognitive processing of the emotional experience, without having awareness of either the affect or behaviour associated with that. The experience

of acting aggressively and/or impulsively without recognising the existence of the affect that has prompted actions, and often still not being aware of having experienced emotion even after having acted on it, impedes the dissociative patient's ability to experience himself as the agent of his own behaviour (Gold & Siebel, 2009).

Gold & Siebel (2009) suggested three goals for intervention that foster reduction in the frequency and intensity of dissociative episodes: 1) reduce the potential for a rapid and unchecked escalation of affect and foster the capacity for emotional de-escalation; 2) increase the cognitive capacities for reorganising the presence of affect for monitoring its intensity and for labelling the type of affect experienced; and 3) increase the ability to refrain from executing behaviour motivated by the emotional intensity of the moment. The therapy should focus on developing these capacities and the clinician should not rely on finding ways to reduce the patient's emotional arousal, but to help patient to cultivate capacity to do this, even after and beyond the therapy.

One of the most important issues in treating dissociation in early phase of therapy is a proper therapeutic alliance between the clinician and the patient. In treating dissociation this is a milestone which should be fully established in the early phase of treatment (*Containment, Engagement*) considering the patient's numerous dysfunctional interactions and interconnections with others due to dissociated state of his personality. A major challenge and paradox of work on dissociation, especially in the event of an extreme dissociative syndrome, is that therapeutic relationship is critical to the attainment of the treatment goals, yet the patient's capacity to form a productive treatment alliance is usually significantly impaired. Lack of the formative alliance may lead to dissociative disconnectedness and, in spite of a desire for the sense of relatedness, the patient will experience the absence of an ability to be connected with clinician that may lead to the patient's frustration, fear, apathy, despair, and feeling helplessness due to dysfunctional attachment (Zepinic, 2011).

For this reason, the clinician should be vigilant for opportunity to develop the therapeutic relations for the patient to learn how to establish the interpersonal connectedness. The clinician's approach to a proper therapeutic alliance should focus primarily on goals of attainment and therapy targets and not just simply giving the patient a "chance" for the narrative. The clinician should also focus on quality rather than quantity, or frequency, of the session(s). Patients with severe dissociation are so precariously oriented to the "*here-and-now*" circumstances that an inordinate amount of time can be spent in treatment without much being accomplished (Gold & Siebel, 2009). Thus, the clinician should be passionate, eager and watchful to indicate the severely dissociative patient's interpersonal detachment.

It is necessary to review the level of therapeutic alliance *patient-clinician* and to assess the degree of patient's retainment and comprehension at all time. This is not for the clinician to assess what is going on during therapy but also to help the patient recognise how much therapy process is helping him to elude mal-

adaptive behaviour and relatedness caused by the dissociation. The clinician's control of therapeutic alliance guards the patient slipping into a fruitless self-disintegration in response to the detachment from others which can lead to further feelings of the helplessness and hopelessness, despair and isolation. Particularly in the early phase of treatment with those patients who are highly dissociative, constant monitoring of the patient's abilities to reorienting to the task of exploring dissociation is required (Zepinic, 2011).

In the course of exploring dissociation, the patient achieves some insight of his own self—he might recognise that his non-relatedness is actually associated with the fears and anticipation of hostilities from people, or his beliefs that he is pitting himself against the others. He should also discover that he harbours something what could be totally beyond fulfilment, contributing to his sense of defeat. Van der Hart et al. (2006) recognised that structural dissociation involves extensive forms of anxiety and fears that have maintained dissociation and restrain functional adaptation.

The most fears of dissociative state are related to: 1) mental action such as patient's inner experience of the emotions, body sensations, and basic needs; 2) dissociative parts of the personality; 3) attachment and attachment loss; 4) traumatic memory; and 5) change and the patient's healthy risk-taking (Van der Hart et al., 2006). Consequently, emotional arousal contributes to the occurrence of dissociative episodes, and interferes with the ability to adequately sustain attention on the immediate present interrupting the connection to the "*here-and-now*" experience. Secure therapeutic relationship improves patient's capacity to overcome inner conflict drives and be ready to challenge dissociated self. It allows the patient to test both maladaptive and adaptive "*if-then*" rules about the attachments (Zepinic, 2011). Van der Hart et al. (2006) was of opinion that the secure attachment is a working model that patient develops only from long experience, and thus is a work in progress during much of the therapy.

4.2. The Mid-Phase of Therapy

As the mid-phase of treatment (*Deepening Understanding; Recalling Traumatic Memories*) starts work on the traumatic memories as a hallmark of the trauma experience, it also inevitable includes further therapy on dissociation. Some clinicians (Meares, 1992; Putnam, 1989; Spiegel, 1995) suggested that dissociation is a coping strategy that arises from the patient's experience of extreme helplessness in the face of trauma. They are also of opinion that an early dissociative response has been found to predict a worse outcome of the trauma. In mid-phase of therapy working on dissociation follows the concept of trauma memories—usual inability to recall and make them narrative. Deeply unconscious, trauma memories cause dissociative reactions with an amnestic state of mind which disorients trauma survivor. In this case, we asked the patient to locate the last thing he remembers before the onset of dissociative amnesia.

Various forms of the trauma-induced dissociative phenomena occur that meaningfully define the *horizontal* (within-stage) and *vertical* (between-stage)

dissociative processes within the framework of identity configuration, structural self-dimensions (coherence, autonomy, vitality, continuity, connection, dynamism), and traumatised personality-trait formation (Zepinic, 2016, 2018). These cause a negative influence on the trauma survivor's capacities, strength, and higher integration within the personality leading to "alarming aspects" of personal identity and the self with constant fear and anxiety. The main aim during mid-phase of treatment is patient's further development of sufficient trust and high empathic capacity. This task includes release of the encapsulated dissociative states by removing maladaptive ego-defences and patient's insufficient information processing of the original trauma experience, and to facilitate the hierarchical integration of the disintegrated (dissociative) parts of 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 change from patient's previously maladaptive affective-cognitive modalities of the functioning into an adaptive and functional self. It may be the case that knowledge of transformative processes into positive, one optimal states of personality functioning is the archetypal expression of the human striving towards unity, integration, individuation, and self-actualisation (Wilson, 2006). As the trauma memories are deeply unconscious, the patient may dissociate in order to protect himself from fear of traumatic memories being released. The therapy should offer to the patient a way to understand unconscious "desire" to withhold traumatic memories not being narrative. Therefore, the therapy should explore areas remote from dissociation and dissociation-focused aspects of the patient's evaluation of the self alterations. From the patient's perspective, there is a series of modifying self-perceptions ("*Who am I*?"), and confusing experiences ("*This is not me*").

In resolving patient's interference in functioning due to dissociative amnesia we used Hilgard's (1986) concept of the "*hidden observer*" in which person registers and stores information into trauma memories—deeply unconscious without patient's awareness and ability to process them. Hilgard's conceptualisation of the "*hidden observer*" is a hallmark of dissociation which alters functions of the self. We emphasise that one's personality is altered and function maladaptively due to disconnected or disintegrated self-structure—the self lost its cohesion and continuity (Zepinic, 2012, 2016). In such distorted self, the dissociative parts tend not to be whole, as it has been before, and stay separated, divided into a lot of small dysfunctional parts.

The dissociated parts also produce a division of consciousness into different disconnected streams. Van der Kolk et al. (1969) suggested that dissociated imprints of trauma 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. During therapy of trauma-induced dissociation, it is important to avoid reconstruction of the traumatic event(s) based on memory fragments, feelings, and fragmented perceptions. Initially, the incomplete and fragmented memory sequences may

give wrong assumptions of the trauma survivors traumatic experience that had caused dissociation. Rosen (2004) stated that, if dissociation involves compartmentalisation and subsequent avoidance of the memories during a stressful experience, then rehearsal of trauma memories should be effectively abolished. This is because the trauma victims with dissociation show chronic fears and anxiety, self-perception of poor physical and mental health, stress on important interpersonal relationships, and a general sense of despair and suicidality.

Some researches (Barlow, 1988) had found the incidence between a panic disorder and traumatic stress with dissociation pointing out that any stressful event weakens the ability of the individual to defend himself against the onset of phobia. Zlotnick et al. (1996), while investigating the long-term impact of the child abuse and complex PTSD, have found the relationship between the childhood abuse and symptoms of somatisation, dissociation, depersonalisation, self-destruction, and maladaptive schemas.

Horowitz (1978) suggests that the 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. Thus, the inability to incorporate this information results in an "information overload" and it is kept out of the conscious awareness, and remains in its unprocessed active form. Because of experiencing "psychic overload", the ego-defences and coping mechanisms fail and the dissociative parts of personality take control over the consciousness. Fear of dissociative parts requires particular intervention that usually extends from the early into the mid-phase of therapy. The change in an individual's rules of safety leads to an expansion in the number of stimuli that become a part of the fear structure.

Foa et al. (2009) stated that many stimuli activate this structure, resulting in frequent bursts of arousal and re-experiencing traumas (e.g., nightmares, flashbacks), alternating the attempts to avoid or escape from such dread fears (e.g., numbness, depersonalisation, behavioural avoidance). Overcoming these fears should be the major therapeutic goals towards achieving a satisfactory level of the patient's capacity for a new cognitive adaptive action and integration. The restoration of meaning and wholeness to personality following trauma is, in itself, a process of unification of dissociative parts of personality into adaptive functioning. Wilson (2006) stated that the process of restoring wholeness to the self-dimensions (coherence, connection, autonomy, vitality) is the main goal of post-traumatic growth. Restoring wholeness of one's dissociated state (personality) involves the process of re-establishing balance and congruence between external reality and inner modalities (Zepinic, 2011).

The therapy in mid-phase focuses on the integration of disintegrated parts of personality into a cohesive (functional) whole and more cooperation among disintegrated parts. Two main characteristics of trauma experiencing should be taken in achieving these goals: 1) most patients assume that a situation is safe in the absence of information signalling the danger, however they never had enough safety signals that no danger exists and hence they are always alert, and

2) some patients experience anxiety and discomfort at a high negative valence, so they are more likely to avoid situations that exacerbate their anxiety (Zepinic. 2011).

The treatment also includes reassurance that each part belongs to the entire sense of self and aliveness/vitality. The dissociative parts can be activated by various stimuli which are not under the patient's control. This may lead to maladaptive changes in the patient's basic emotions, goals, and behaviour; this is problematic perception-motor action cycle (Van der Hart et al., 2006). The maladaptive changes then bind any capacity in feared avoidance to the inner conflicts attached to the dissociative parts of personality contributing to further decrease in the levels of adaptive functioning.

Overcoming fears of the dissociative parts of personality requires a high level of activity not only from the patient but from the clinician too. All interventions should be designed to promote synthesis of personality as a whole and it is common that patient is unable to recognise essential distortions of personality simple because he is afraid even to trust to his own thoughts. As a result, patient avoids "remembering" what happened in the past blaming his "amnestic state" for fragmented or limited recall of traumatic memories. He tends to compromise his senseless existence, his aliveness or togetherness, spontaneity, and individuality. Severely traumatised patients may become exhausted in their struggle against the self-destructive urges and thoughts: "*This life is so empty—just uneasiness and pain… I feel like I died—all my dreams died… I feel like a different person completely out of the world…*". Then dissociation and negative thoughts oppose the self-continuum keeping patient in "*there-and-then*" contrary to the patient's desire and therapy goals of "*here-and-now*" concept.

Thus, the clinician focuses in strengthening therapy on a particular part and its maladaptive mechanism helping patient to simplify life and rebuild his safety in order to decrease his maladaptive behaviour and improve mental energy. When the clinician assessed that some dissociative parts have lower impacting power and cause a minor or fears to the patient, it is a chance to impose a *gradual imagery exposure* giving to the patient greater likelihood of success and raising mental level for further imagery exposure treatment. This will bring a systematic intervention towards dissociative parts of the personality and therapy itself will be effective.

The clinician should be aware that the patient's dysfunctional self may demonstrate resistances to the challenges. No matter which dissociative part is going to be treated first, the clinician should reassure patient that therapy will progress. In essence, the patient's resistance is his unconscious question whether therapy could attend to each dissociated part and make all of them "agreed" to make a cohesive personality, or a whole system. As dissociative parts are very powerful and maladaptive, for the patient it seems almost senseless to treat them and make any challenge. Also, the patient may assume that the treatment will be a process of hurting or scaring the dissociative parts and they may use "their power" against the wholeness of personality.

This feeling may create strong urges to avoid dealing with overwhelming issues and the patient's beliefs that it is impossible to treat dissociative parts towards their unification into one functional system as a whole. Thus, the clinician should elaborate to patient that all dissociative parts belong to one personality, and all of them must find the ways to "*communicate, understand each other, and work in harmony as a whole*". Then patient becomes conscious of his maladaptive feelings, behaviour, and regulatory needs. Overall aim is to help patient's awareness that inward and self-destructive thoughts are influenced by the dissociative parts of personality induced by the trauma and not by any other reason.

4.3. The Final Phase of Therapy

The final phase of treatment (*Self-containment; Enhancing Daily Living; Relapse Prevention*) is mostly focused on transforming one's dysfunctional self. As severe trauma may shatter all structures of the self and its coherence and continuity, the clinician is faced with task to transform such self into functional stage. Mostly resolving maladaptive feelings about self during the mid-phase of therapy, further stage is focused in helping patient about his new interpersonal and intrapsychic patterns, moving from a baseline of friendliness towards the self and others that include degrees of enmeshment and independency.

Transformation of self improves functioning of the self-structure and patient's control of the inner conflicts. The self moves from its "*self-at-worst*" stage—division and depletion. In principle, the cohesive self-structure tends to emerge optimally in "*here-and-now*" circumstances overruling one's a long-standing shattered state, fragile, incoherent and inadequate self. Having developed his "*insight*", the patient is able to review specific and current relatedness in the light of input, response, and impact on the self. Recognising these connections, the patient anticipates needs to block eventual repetition of the past ("*there-and-then*") patterns. Regarding the trauma-induced dissociation, the final phase of therapy supports patient's self-discovery in 1) accepting what *it was* and what *it is* and moving forward, and 2) making mindful and benevolent choices (Zepinic, 2011). Self-discovery activates mostly focus on maintaining motivation to move beyond the traumatic past.

Therapy to help patient's self-management is based on: 1) identifying and practicing new, constructive patterns, and 2) resisting any desire to go back to old ways of management influenced by the inner impulses and traumatic past. However, even being in a final phase of therapy, patient still may express some "fear of newness and progress achieved" which indicates uncontrollable feelings of the "newness" due to the accustomed loss of habitual ways being present for long-time. The patient's fear of "newness" should be elaborated and he should be encouraged to practice already used coping strategies and, at this time, helped to recognise discomfort (therapy is still on, not finished), and together with the clinician, patient would move a step ahead from the threat or fear to regress into old ways of coping (defensive strategies).

In addition to deal with the "fear of newness", therapy should provide skills how to resist eventual powerful inner conflict drives so that he could be able to focus on what *is* and *to be.* However, instead of directing patient's approach (what was commonly done in the early phase of therapy), the clinician should impose principles of enhancing the patient's personal strength enabling independency. Thus, the clinician rather gives some advice for specific interpersonal and intrapsychic contexts, including needs for further relatedness that will support a sense of self-continuity and connectedness (Herman, 1992; Holms et al., 2005; Steele et al., 2005; Zepinic, 2011).

The sense of self-continuity and connectedness with others help to maintain the patient's emotional stability by providing a course of predictability and certainty for real life and successful management of challenging life-events. This helps in developing the patient's positive sense of post-traumatic growth (Wilson, 2006). Through the self-continuity and meaningful relatedness, the patient develops an existential awareness of his capacity to rebuild a new self from the divided pieces and reinvent the architecture of a new self and self-structure. The sense of self-continuity also provides feedback information from the others testing a new self and post-traumatic capacity for changes. This also helps patient to maintain a psychic equilibrium as the psychological integrity which was groundless and centreless during the trauma experience.

Disintegrated equilibrium has been experienced in various forms like tendencies towards separation, loneliness, isolation, purposelessness, alienation, detachment, and psychic numbing (Zepinic, 2011). The transformative principles of the establishing positive self-continuity within the other sources of meanings and attachments are fundamental to healing and recovery from the trauma complexes (including dissociation) and damage to the inner self (Phillips & Frederick, 1995; Wilson, 2006; Zepinic, 2009, 2017). Transformation process includes reinvention of one's new self-coherence and continuity making different baselines of sameness and continuity of the patient's life. The clinician's active empathic and compassionate response could always be "*an emergency help*" but the trauma victim's *independent self* should also be capable to function out of therapy session, not having the clinician's "cognitive guideline".

When the self is transformed from dependency into autonomy, the therapy should stay within a spectrum of the possibilities where the patient's individuality and activity will contribute to a restoration of the haunted self by trauma. This, in fact, has been the best possible way of the emphatic contribution—the approach of a psychologically perceptive person *vis-à-vis* someone who is suffering and has untrusted himself to the clinician for help. Lack of the emotional responsiveness would contribute to abnormal features of the patient's psychological make-up of the self. In this regard, a maintenance of connections between the inner dimensions of the self (continuity, coherence, connection, autonomy, vitality) and a sense of connectedness to external sources of meaning (society, culture, group) is essential for an inner sense of continuity and self-sameness, sustaining existential meaning of life on a daily basis.

The patient's awareness of a positive shift brings consciousness of the "*here-and-now*" existential state and inner sense of continuity reinforcing a sense of personal identity and life continuity in time and space. Integration of the fragmented self-coherence is a vital issue in restoring aliveness/vitality and wholeness of the self. The self is not anymore run by its inner impulses, fears, anxiety and what entirely represented inner chaos and the self-decentring. Wilson (2006) was of opinion that there are polarities in the posttraumatic self: coherence *v* fragmentation*;* continuity *v* discontinuity; connection *v* separation; autonomy *v* overcontrol; vitality *v* lethargy; and energy *v* mental fatigue*.*

Through his self-recovery and its transformation, the patient develops adaptive personal identification with the others and relatedness. There is a redeveloped sense of belonging, empathy, and compassion for the others on the principle that "external world is not any more a dangerous place". At the same time, the patient recognises his awareness that trauma caused increased feelings of unfairness, injustice, inequity, and suffering, and made him more vulnerable than others. Such transformed self is capable of extending its boundaries to other measures and values, and self-identification without fears of rejection or even embarrassment.

In the final phase of treatment, patient is in "self-representation" position and not any more in a stage of the clinician's interpretation of "patient's self", as it was in previous two phases of therapy. He is in all reality—psychological (the world via introspection), and physical (the external world is perceived by senses). Strengthening the self in therapy by emphatic resonance with the clinician allows the patient's self to experience learning in an *out-of-session* context.

Thus, therapy made the self again more adaptable to demands from the external world. Distorted aspects of the self's experience of itself and of the others come into renewed contact with a different reality, which it may experience as benign and which it learns to understand and to which it may then gradually re-adapt itself (Van der Hart et al., 2006; Wilson, 2006; Wolf, 1988). The transformational process requires to converting trauma-induced dissociation and subsequent dysregulations into the core dimensions of the personality and self-capacity into the optimal states of an integrated organismic striving (Wilson, 2006; Zepinic, 2011) which helps to restore the balance between external reality and internal modalities of the experience.

Enhancement of the self-concept is defined by two interrelated elements: self-efficacy and self-worth. Self-concept is a complex construction entitling an inner representation of the self assembled with memories, thoughts, sensations, and affects. Self-efficacy is defined as an experience-based assessment where the self has the tools and skills to function adequately and positively (Omaha, 2004). Fundamentally, self-concept contains elements of the self-worth (self-valuation) that appears as a statement towards the self or as a degree of how much one's self is accepted by itself and others. In the trauma-induced dissociation, worthlessness is a basic element of the depleted sense of self with sufficient dichotomy in the emotions and behaviours. Thus, the dissociation is an escape from any cir-

cumstance that tests dichotomous feelings. Viewed in this light, due to negative beliefs about the self, dissociated self-worth is seen as *it is* than as *it could be.*

The trauma victim is not able to balance between these two states and, due to the dissociation, prefers to worthlessness which constitutes self-worth. Basically, the therapy is focused on changing perception from "*I am worthless*" to "*I feel worthy about myself*". During the therapy, the traumatised self's self-worth receives some new developmental perspective that will potentially bring pre-trauma level—proper self-dimensions, a new quality of personality, and behavioural functioning.

While treating the trauma-induced dissociation, we emphasised the importance of self-containment simple because complex trauma causes strong emotional outcomes. It also provokes strong emotional reactions while processing trauma experience (memories) in order to develop new relatedness. Thus, processing of trauma experience may affect the strength of self-containment and impact the process of developing new attachments. We consider that developing a strong self-containment—self holding and being held by others—is one of the main tasks and primary goal in the final phase of therapy. For an individual with complex trauma who had been emotionally overwhelmed by the traumatic past and having dissociated self for a while, therapy needs to focus on self-containment rather than simply processing traumatic experience (memories).

With a strong self-containment processing, controlling emotions and thoughts associated with the traumatic past is not a painful process for the patient. Understanding that the dissociated self does not ultimately mean "loss of mind", the patient is capable of the re-processing his self-continuity and cohesion. During this process, the patient is encouraged to explore his disturbed attachments by trauma, such as isolation (denial of attachment needs), repetition of the traumatic attachments (survivor's skills), or insecure attachment (the world is a dangerous place).

Therapy should focus on the patient's ability to tolerate frustration, resolve conflicts, and separate the past time (*there-and-then*) from the present time (*here-and-now*). In some cases, such as brutal rape, the patient may dissociate physical or emotional intimacy. When commenced resolving this dissociation, the patients usually experience burst of physical symptoms (sweaty palms, shaking, heart palpitations, air gasping, ...) with loss of ability to think and/or recall. They have not been aware about their arousal reactions, spontaneous body movements, and almost an inaudible speech. Sexual intimacy presents a particular barrier in treating dissociation (Foa et al., 2009; Herman, 1992) as psychological processes of arousal are compromised by deeply unconscious traumatic memories.

During therapy of rape-induced dissociation, the patients may unconsciously make self-defence, including putting their hands in front of their body, backing away from the clinician who stands up or leans towards the patient, or pulling back while sitting. Some patients feel very uncomfortable and ashamed of their behaviour and arousal during therapy. However, the clinician should encourage

patient to express freely any negative emotions, thoughts, or psychosomatic reactions associated with the trauma experience—their unconscious responses and arousal are part of their trauma attachment system.

The dynamics of the patient's adjustment is conducted by means of the focused sessions helping his full social integration and interpersonal relationships. Out of therapy session, the patient is advised to find face-to-face positions in relating without support by clinician but using trained skills how to avoid his resistances to the relatedness. The patient is in position to discover and modify factors that provoke such arousal, by assessing assets and liabilities and by mobilising all the available positive parts of his personality. In the form of a proper rapport with the clinician, the patient feels secure of even making mistakes as he brings into awareness meanings of the interpersonal conflicts that had contaminated his previous relatedness. Maladaptive attitudes are explored demonstrating that the patient is able to cope difficulties outside therapy session.

As the patient is capable of dealing and controlling the inner conflicts, less burden is placed on exploring the origins of their existence while more emphasis is put in (re)organisation of habits, regardless of the sources of the constitution or specific meanings. In this phase of therapy, the patient comes face-to-face with the attachment difficulties in realistic form not influenced by the traumatic past that originally produced the disturbing (dissociated) character of views towards own self and the world. As a part of these abilities, the patient is capable to change his attitudes of attachment and accommodate them accordingly. The patient is essentially encouraged to rectify remediable environmental difficulties, to adjust towards irremediable obstacles while finding adequate compensation or sublimations to enhance his resources and activity. He is in a stage of abandoning unrealistic goals, without anxiety and arousal that discourage his ambitions and realistic plans. The clinician takes part in initiating and highlighting the patient's healthy personality elements that are actual and which have the potential to mediate pathologic patterns of adjustment (Zepinic, 2011).

4.4. The Termination Phase of Therapy

The termination phase of therapy (*Independency; Integration; Steps Forward*) is about completing therapeutic goals, consolidating patient's changes, and bridging the future. Although there is no red line between the therapy phases, termination phase could be also seen as a part of the final phase, and not separate. As a general principle of any therapy, planning for the ending treatment should be from the assessment and making therapy strategy and aims—to accomplish therapeutic goals in healing and recovering patient's condition. In essence, termination phase has a little work with trauma-induced dissociation as this problem has mostly been treated in the previous three phases.

During termination phase the focus should continue on a relapse prevention as some patients may still experience interpersonal problems even after the PTSD symptoms have been treated. Such patient may benefit from interpersonal skills training which serves as a form of the *in viva* exposure. Interpersonal

training also is a potent vehicle for eliciting maladaptive beliefs about interactions with others (Levitt & Cloitre, 2005), which can be targeted with cognitive restructuring while treating traumatic memories.

Even patients being successfully treated regarding their trauma-induced dissociation they still tend to be at increased risk for future trauma exposure compared to people who have never been traumatised or developed PTSD. At the end of treatment, clinician should inform the patient that experience of the traumatic event(s) makes greater risk for future trauma and re-development of PTSD. However, the patient's risk for re-traumatisation needs to be examined on a case-by-case basis. Clearly, those who have dangerous occupations or live in dangerous neighbourhood should be encouraged to avoid or reduce their risk of future trauma exposure.

This may involve reviewing the warning signals of the patient's previous traumatic experience (e.g., rape, kidnaping, torture, or some other violence or assault) and devising guidelines for identifying any threat. Further, impulsive or excitement-seeking personality traits can increase the risk of re-traumatisation. Such patients are at risk for PTSD if they have a high score on personality measures of negative emotionality and they are liable to put themselves, sometimes inadvertently, in dangerous situation. In such cases it can be helpful to work together with patient in finding more adaptive and less exciting behaviour.

Termination phase also include a work on assertiveness—standing up for one's rights or preferences without trampling on the rights of others. Assertiveness also involves being able to express one's feelings to others, whether they be tender feelings (e.g., telling a spouse that you love him or her) or negative feelings (e.g., discussing a problem you have with a co-worker). Assertiveness problems merit treatment in their own right and they are more important when contribute to development of PTSD. Unassertiveness, on the other hand, may worsen avoidance symptoms, and aggressive behaviour can fuel hyperarousal.

5. Conclusion

The concept of psychological trauma and indeed, research and therapy about trauma-related disorders have reached an all-time peak during the past three decades. The causative impact of the stress disorder and associated problems upon whole personality has been well known and recognised for a long time, and requires finding the most effective treatment. Psychological trauma impacts on somatic, cognitive-affective, and behavioural aspects of the trauma victim's dissociated personality. There have been different diagnostic and therapeutic approaches since 1980 when DSM-III (APA, 1980) for the first time recognised PTSD as an independent diagnosis. In DSM-5 that published in 2013, PTSD is included under new title *Trauma and Stressor Related Disorders* and diagnostic criterion is an exposure to actual or threatening death or serious accident that must result from one or more of the followings: directly experiencing the traumatic event, witnessing the traumatic event in person, indirectly by discovering that the traumatic event occurred to a close family or close friend and experi-

enced to extreme exposure to bad details of the traumatic event (APA, 2013).

Long before PTSD has been defined, the clinicians (Janet, Charcot, Freud, Kraepelin, Kretschmer, ···) had observed that severe (complex) trauma may cause dissociation in the traumatised personality. Trauma-induced dissociation has been differently defined, but in essence, the clinicians agree that the dissociation is a *division* of the personality or of the consciousness—divisions among system of the functions that constitute one's personality (Zepinic, 2012). Apparently, finding an effective treatment of dissociation has even been more complex obstacles. In general, there are several therapeutic models in treating PTSD (CBT, CPT, CR, PE, TFCBT, etc.) involving many components of the techniques to therapy: exposure to trauma reminders, education about patient's common reactions to trauma, relaxation trainings, identification and modification of distortions. However, there is no research which would advise the most effective therapy model for syndromic condition of the complex trauma.

Some therapy models are more effective in treating specific symptoms, however, as in most cases complex PTSD is a syndromic condition, not a simple disorder (Courtois & Ford, 2009; Ford, 2009; Herman, 1992; Steele et al., 2005; Van der Hart & Boon, 1997; Wilson, 2006; Zepinic, 2011). It is necessary to accommodate any therapeutic approach to complex trauma complexity and severity of its symptoms, including treating the trauma-induced dissociation. Furthermore, some techniques of therapy (such as *in viva* exposure to the trauma reminders) may increase severity of symptoms due to the further traumatisation.

In essence, treating complex PTSD should include strategies of trauma-focused therapy which addresses the patient's troubling traumatic memories, personal meanings of the trauma experience and its aftermaths. Based on over a decade of clinical experience in treating numerous severely traumatised patients, we had developed the *Dynamic Therapy* model which applies to *holotropic* integration of the distorted self into a whole (Zepinic, 2004, 2011).

The main concept of this model (Zepinic, 2011) includes three therapy goals: 1) restoration of the forms of one's relatedness ("*Interconnectivity*"); 2) restoration of sense of the aliveness/vitality ("*Dynamism*"); and 3) restoration of awareness of self and inner events ("*Insight*"). The theoretical concept of the *Dynamic Therapy* model was based on clinical experience that disturbances of trauma victim's self-structure—one's image of the body and sense of self (both often dissociated)—caused by severe trauma leads to a sense that the coherence and continuity of the self is systematically broken down.

Disturbances of self-structure may cause a sense of an identity diffusion (dissociated state of one's identity), fragility, and feelings of the self-discontinuity, with severe disruption in one's psychological equilibrium and relatedness (Zepinic, 2011). The *Dynamic Therapy* model is phasic (three or four phase model) and individually designed therapy which does not have a sharp line between the therapy phases—they are interconnected and support each another. The model cannot be strictly regarded as a specific theoretical concept—it is a

multimodal system and casts as cognitive-behavioural-analytical-dynamic approach. In clinical practice, the model does not apply in a strict linear model, but rather takes the form of continuum attention to tasks various phases alternatives.

In treating trauma-induced dissociation it is often unclear if the patient will be capable of integration his traumatic past. This is mostly because such patients experience dissociation for a long period of time prior to seeking treatment. They represent a very heterogeneous complex group—enmeshed patients, who are the most recalcitrant to therapy and who tend to remain enmeshed having accustomed "dissociative" lifestyle, and participate in self-destructive behaviours and habits.

When the diagnosis of the trauma-induced dissociation has been made with the patient, therapy as a rule is aimed at stabilisation and symptoms reduction (including containment of the traumatic memories). Factors that may influence therapy strategy are: 1) patient's current functioning; 2) nature of severity and complexity of the comorbid condition (dissociation); 3) patient's ego-strength and capacity to utilize attachment figures for self-soothing; 4) patient's life cycle phase since trauma experience; 5) ongoing enmeshment with the past; and 6) external life crisis (Zepinic, 2012). When clinician and patient, after a thorough assessment, analyse above obstacles and eventually agree on these matters, the early phase of therapy (stabilisation) can be followed by the treatment of traumatic memories, as well as the personality reintegration.

The early phase of therapy is aimed to regaining some stability in daily life, to symptom reduction, and to establishment of personal safety and self-care (Herman, 1992; Zepinic, 2011). The clinician should pay careful attention to this phase as it could be a key point for patient's strength to face with quite complex issues following retrieval of the traumatic memories. In our clinical practice, the clinician in early stage of therapy contacts preferably only identities which actively participate in patient's daily life. Then further "introjects" in patient's inner conflicts can be helpful in reducing instability, inner unrest, and the self-destructiveness.

In early phase, the clinician should emphasise inner conflicts contribution to the patient's dissociation and "invite" their help to prevent their reactivation, as much as possible, to avoid patient's self-destructiveness and other trauma-induced emotions. All of this is based on the clinician's and the patient's cooperative work together of gradual exposure of dissociative identities to one another, and of fostering cooperation instead of inner fights and avoidance, aims at overcoming the phobia of dissociative identities and trauma memories (Van der Hart et al., 1993). At this phase of treatment, the clinician should in details overview patient's symptoms and subpersonalities in order to find how stability can be reached, in particular in areas of daily functioning, and to reduce crisis.

In clinician's approach to gradually contacting altered identities, it is not aimed to make complete picture of existing identities but identify their impact on patient's functioning. It is important to make behaviour contract against the

patient's suicidality with the whole system of altered identities. Even if patient does not report evident signs of suicide, the clinician assumes that this could be "survival" value due to severe traumatisation and its wake by the reminder (Zepinic, 2001, 2015), in particular of aggressive altered identity. Discussion with patient about this issue should be constructive (e.g., discuss situation that aggravates the symptoms and triggers the destructive blackout) in order of achieving the patient's better dealing until the traumatic memories, which evokes these emotions, become integrated (Zepinic, 2015).

Although the mid-phase is mainly targets traumatic memories, in this phase work on dissociation continued alongside with treatment of the memories. It is phase in which the transformation of dissociative traumatic memories into the patient's autobiographical (narrative) memories of the traumas is decisive for the entire therapy (Zepinic, 2009). In order to bring this transformation, the clinician guides the patient with intensive episodes during which dissociative aspects of the traumatic memories are evoked, re-experienced and "brought together".

This is a concept of the *synthesis*—controlled imagery exposure to the feared traumatic memories (avoided by continued dissociation of the memory) under conditions of the response prevention. The result of *synthesis* is that dissociation is lifted and traumatic memories cease to exist, and that patient gradually becomes able to relate the narrative of the trauma realising what has been done to him during trauma experience. *Synthesis* sessions are usually alternated with sessions in the early phase of therapy aimed at stabilisation. The long-term task of the trauma-work is to integrate the autobiographical (narrative) memory into the whole of the personality (Van der Hart & Boon, 1997).

During the final phase of therapy, with terms of healing altered personality by traumatic memories (dissociation) in previous two phases, the goals are guiding patient with further integration and unification of the personality. Guided imagery fusion into whole should be controlled, not spontaneous, as altered identities and disconnected parts of the self had shared so much against each other that staying apart would lose the self's functions (Zepinic, 2016). In our clinical experience, we found there is still an inherent avoidance (confrontation) among disintegrated parts of the personality; not completely integrated patient remains vulnerable for dissociative fragmentation when new stress occurs by a reminder.

Nevertheless, as has been presented in this paper, there is a general agreement that the phase-oriented therapy of trauma-induced dissociation is the most effective. Our clinical practice in which the patient's dissociative capacities are constructively used (imaginary safe places and for containment traumatic memories) with very gradual inter-identity exposure, in order to "brought together" disintegrated parts of the self, brings one's severely traumatised personality into a pre-trauma functional level.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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