

## Treatment Resistant Symptoms of Complex PTSD Caused by Torture During War<sup>1</sup>

Vito Zepinic<sup>[a],\*</sup>

<sup>[a]</sup>Ph. D., Psychclinic P/L, London, United Kingdom.  
\*Corresponding author.

Received 16 March 2015; accepted 6 August 2015  
Published online 26 September 2015

### Abstract

**Objective:** The purpose of this study was to evaluate the severity and complexity of a treatment resistant PTSD caused by torture during war. The inclusive criteria included the experience of torture and no efficacy of provided therapy after five years of being treated due to severe war-related PTSD.

**Method:** The study was conducted on 24 treatment resistant PTSD patients from former Yugoslavia who had been tortured during their captivity as the POW. Despite being already diagnosed and treated due to their war-related PTSD, all patients were screened by the Structured Clinical Interview for DSM-IV (SCID), MMPI, and the Posttraumatic Stress Diagnostic Scale (PDS).

**Results:** Results of the initial assessment revealed that 19 out of 24 patients satisfied criteria for treatment resistant symptoms of complex PTSD due to severe trauma experience.

**Conclusion:** The treatment resistant PTSD is a very complex condition that requires various ways to make real contact with, endeavour congruent, emphatic and unconditional positive regards for the patients. It is important that clinicians do not use a 'copping' but qualitative and idiographic individual approach to each patient finding differences value alongside.

**Key words:** Complex trauma; POW (captivity); Torture; Treatment resistance

Zepinic, V. (2015). Treatment Resistant Symptoms of Complex PTSD Caused by Torture During War. *Canadian Social Science*, 11(9), 26-32. Available from: <http://www.cscanada.net/index.php/css/article/view/7551>  
DOI: <http://dx.doi.org/10.3968/7551>

### INTRODUCTION

When someone kills a man, he is taken to prison. When someone kills twenty people, he is declared mentally insane. But when someone kills 200,000 people, he is invited to the UN for a peace negotiation.

(Joke from Sarajevo, 1992)

By definition, chronic (complex, type II) PTSD is a psychiatric disorder consisting of physiological and psychological responses resulting from exposure to an event or events involving death, serious injury, or a threat to physical integrity. Clinical evaluation for PTSD requires assessment of symptoms within each of three main symptom clusters: re-experiencing, avoidance/numbing, and hyperarousal. Obtaining detailed history of the exposure and the patient's early responses to the trauma can provide important information not only to evaluate symptoms but also to obtain useful information for treatment and prognosis. It is helpful to ask more specific questions, but it could be also risky, and the clinician should consider how much re-trauma might result (eg. sexually abused individuals) from reminding a patient about the traumatic experience. However, the presence of dissociative symptoms often prevents the patient from recalling particular details of the trauma, feelings of fear, horror, and despair that can cause lack of clinical judgement in determining whether the required criteria for diagnosis has been satisfied.

Chronic (complex) PTSD is a very complex disorder in its epidemiology, aetiology, psychobiology, comorbidity, and treatment approach. Due to its complexity it is often difficult to understand the pathophysiology of PTSD and

<sup>1</sup> This article was presented at XVIII European Congress Psychotherapy, Valencia, Spain, 4-7 July 2012

to develop an effective treatment. This complexity extends over the entire range of the PTSD abnormalities: the deregulation of many neurobiological systems, personality changes, distortion of the patient's appraisal process, the disruption of learning and memory, and alterations of both tonic and phasic mechanisms, and the difficulties caused by the neurobiological shift from homeostasis to allostasis. This is particularly caused by the severity and duration of trauma exposition, developed trauma memories system, and time to start with a therapy. Four magnetic resonance imaging studies (McDaniel et al. 1995, Morton et al., 1984; Davis et al., 1986; & Baile et al. 1992) have shown that chronic PTSD is associated with a lower than normal hippocampal volume. To those who were exposed to prolonged and severe repeated trauma the severity and chronicity of PTSD symptoms are likely to occur but also will make treatment more complex.

Torture is a severe and complex traumatic experience and it is defined as the wilful and deliberate infliction of pain and suffering by the person or persons for the purposes of obtaining some information, coercing the will of the victim, or for other purposes. The World Medical Association defined torture as '...deliberate, systematic or wanted infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reasons' (Tokyo Declaration, 1975).

Long-standing and extensive torture usually causes a severe (complex) trauma and a chronic PTSD. High levels of PTSD symptomatology persist for many years and the patient is usually impaired for life. Extensive torture can destroy any sense that human beings are intellectual creatures and that the world is a manageable place. During his testimony at the ICTY, The Hague in 2003, the author of this article stated that: human is only animal among the species who is a mass murderer and tortures his own race. The hallmark of the PTSD with patients who have been exposed to severe torture is that the problems show up and persist for a long period of time, often turning into the treatment resistant and life lasting condition.

People being exposed to the longstanding torture developed 'torture syndrome' that could be summarised in four groups of the symptoms: (a) psychosomatic (pain, headaches, tremor, gastrointestinal problems, sweating, weakness, dizziness, nightmares, flashbacks), (b) affective (anxiety, depression, phobias, panic), (c) behavioural (irritability, sexual dysfunction, social withdrawal, aggressiveness, suicide), and (d) intellectual (poor concentration, memory deficit, confusion, attention span impairment, disorientation). During the therapy there are common signs of the patient's constant fear of dying or being punished. It is also common that individuals who were held in isolated cells suffer panic disorder with phobias (agora or claustrophobia). In clinical practice

these patients could show inability to undergo a blood test or MRI examination due to suffer phobic symptoms.

## 1. TREATMENT RESISTANT PTSD

Individuals who have been tortured and exposed to danger such as a loss of life, physical injuries, and lack of sleep, food deprivation, and threat, are of high risk to suffer a chronic (complex) PTSD, particularly if exposed on long-term effect (Herman 1992; Horowitz, 2001; van der Kolk, et al., 2005; Zepinic, 2011). Being tortured during imprisonment as a POW, often leads the individual to lose his identity, to develop guilty feelings, sense of failure, and shame of being alive. Physical or psychological torture of extreme frustration and humiliation usually makes PTSD symptoms difficult for the treatment, or treatment resistant condition. Many studies of the POW captivity and exposition to long-term torture (Allen, 2005; Bremner & Brett, 1997; Briere & Spinazzola, 2005; Courtois & Ford, 2009; Herman, 1992; Tennant, Goulston, & Dent, 1986; Zepinic, 2008, 2011) found the signs of various psychiatric disturbances decades after original trauma occurred. The most prevalent symptoms reported were sleep disturbances, recurrent dreams of the traumatic event, and recurrent and intrusive recollection of the event.

The differences in PTSD symptomatology were attributed to the duration and severity of the traumatic experience while being captive. The patients (POW) who were held captive for a long period of time and subjected to a prolonged and extreme torture, or extreme harsh physical conditions, often suffered chronic (complex) PTSD that requires a long multidisciplinary therapeutic approach and might result in treatment resistance or relapse. With these patients the symptoms of PTSD over time became less prevalent but usually do not disappear entirely and the recovery is not complete. Some severely tortured POW developed the persistence of the 'survival skills' which exist long after being released from imprisonment or captivity (Zepinic, 2012). The patients show a vulnerable self-structure evidenced in the following aspects: (a) difficulties in self-regulation, such as self-esteem maintenance, affect tolerance, a sense of self-cohesion and continuity, or a sense of personal agency; (b) appearance of symptoms, such as frequent upsurges of fears and anxiety, depression, or irritability; and (c) the individual's reliance on primitive or less-developed forms of the self-object relatedness with attachment figures (Zepinic, 2012).

Many tortured victims suffer significant symptoms of PTSD that appeared in full complexity while being treated. The main goal in treating victims of torture is to restore a state of psychological wellness and normal functioning. Although many patients with a chronic PTSD could improve with adequate treatment (medical and/or

psychological), a significant proportion of them fail to reach a desired level of functioning and wellbeing.

In medicine, the term 'resistance to treatment' is usually used to define patient failing to respond to a standard form of treatment. Similarly, treatment resistant PTSD applies to those patients who do not resolve symptoms although they have been treated adequately with pharmacological, non-pharmacological, or combined treatment approaches. One of our patients M S stated: *I lost basic trust in human relations and I try to distant myself from others... my experience is shameful to my family and I am under significant suppression of my emotional feelings*'. The severity of his trauma symptoms caused resistance to treatment and his traumatic memories 'overwhelmed his daily life'. Traumatic experience lies outside the normal range of human comprehension and cannot be assimilated in part because it threatens basic assumptions about oneself and one's place in the world (Zepinic, 2008).

The definition may vary widely and there is no universally accepted definition for how long a patient should be treated with no progress that would be accepted as a treatment resistant. However, considering the onset of PTSD and symptoms, it might be accepted that after twelve months of treatment failure would be acceptable definition. Of course, the clarification of this depends on adequate treatment trial and specific expectations for treatment outcomes.

In rare cases, particularly with severe trauma, it may be unrealistic to expect that some patients will ever improve the level of high functioning and wellbeing, or pre-trauma condition. On the other hand, it is reasonable to assume that any distressing recollection of the trauma may induce remission despite previous effective progress. When treatment resistant PTSD is defined as a failure of responding to the provided treatment the clinician should review all possible predictors of failure including patient's compliance to the treatment, the use of valid outcome of measures, and real expectations of functioning.

It is important to make a distinction between treatment resistances and relapse. These concepts could be difficult to be distinguished on the basis of clinical observation without long-term systematic evaluation particularly in patient's daily functioning. To complicate this issue further in the assessment and clarification of the treatment resistance, given feedback of the patient's daily functioning causes an underestimated efficacy of the treatment provided. In theory, treatment resistant PTSD could be used to describe patients with an initial response to the therapeutic approaches but no significant improvement achieved, with respect to resolve symptoms, and improved sense of self, and functioning.

---

## 2. SUBJECTS

---

The study was conducted with 24 male patients who were refugees from former Yugoslavia. Of the subjects, 19 had been employed before the conflict started and 5 had been students. All of them were civilians and reported no history of involvement in any combat, militia, or army during civil war in former Yugoslavia.

They reported no prior history of any crime, prosecution or imprisonment. The mean duration of spent time in war prison/camp was 2.3 years. Of the subjects, 80% reported having experienced a mean of 5 different types of the torture. The most commonly reported methods were psychological torture (threats, swearing, being forced to witness others being tortured), beating, falanga, cold-water shower, cutting a wound with a knife, burning with cigarettes, and food/water deprivation.

---

## 3. TESTING

---

All subjects were carefully screened (despite already being diagnosed having a chronic PTSD) by using the Structured Clinical Interview for DSM-IV-TR (SCID), translated and standardised MMPI, and Posttraumatic Stress Diagnostic Scale (PDS), in order to identify the profile of diagnosis, symptoms severity, symptoms description, and level of the impairment. Diagnostic assessment was made by trained clinicians on the basis of structured interview, without involvement of the interpreter.

The group subjects mean age was 34 years ( $SD=8$ , range 24-46). All subjects reported already being prescribed medication and 21 of 24 subjects reported heavy smoking cigarettes. There was no history of alcohol abuse or drugs dependency prior to the trauma, but 17 of the patients reported heavy drinking problems since being released from a prison/camp. None of the patients reported history of any previous mental illness prior to the captivity.

---

## 4. ANALYSIS

---

Psychometric tests and clinical interviews were performed to examine the presence and severity of the PTSD symptoms despite provided treatment, which indicated a treatment resistance. We also assessed the presence and symptoms of other psychiatric disorders (anxiety, depression, paranoid ideation, phobias). It was also important to assess patient's general medical condition that could be one contributing factor in development of the treatment resistant PTSD.

The criterion A and E of PTSD from DSM-IV has not been of particular interest as collateral information already satisfied this criterion. Clusters B, C and D of DSM-IV-TR (APA, 2000) were screened and the criterion F has been evaluated subsequently.

## 5. RESULTS

After using screening instruments, we found that 19 out of 24 subjects satisfied criteria as suffering the treatment resistant PTSD. In spite of having treatment more than twelve months (average 26 months) all subjects have reported re-experiencing the trauma that satisfies diagnostic criterion B of the DSM-IV-TR. The most severe were distressing dreams of the torture, intrusive recollection of the traumatic event(s) including thoughts and images. However, all subjects were evaluated as having persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, as described by criterion C of the DSM-IV-TR. These symptoms have caused clinically significant impairment in patients' social, occupational, emotional, and other important areas of functioning (criterion E of the DSM-IV-TR).

Persistence of symptoms at mean 3 from criterion D of the DSM-IV-TR was evaluated among all patients. The most disturbing was difficulty falling or staying asleep. Ten patients reported fear of going to sleep due to traumatic experience of being awoken several times for the interrogation or torture (physical or psychological). Difficulty concentrating and level of impaired attention span were also evaluated with all patients.

We summarised reported symptoms in the following groups: anxiety, behavioural problems (aggression, antisocial, disorganised, suicidal, reckless activity), lack of energy, disturbances in cognition/attention/memory, occupational and social impairment (relatedness), sleep disturbances (nightmares, inability to fall asleep), flashbacks phenomena, mood/affect disturbances, perceptual disturbances, and sexual dysfunctions.

It was evident that traumatic event(s) was an assault upon the victims sense of self as all structures, the image of the body, the intermittent images of others, the values and ideals, were disturbed which lead to sense that coherence and purpose are invaded and systematically broken down. Three aspects of the self-experience were affected by the trauma: self-worth, self-efficacy, and self-continuity. To be traumatised is often to be overpowered and rendered helpless which develop a sense of futility, surrender, and languishment. One of our patients described his sense of self *"the anger toward myself took a lot of my self-confidence, my mental energy, and self-identity. The memories of my trauma hurt me deeply and I ask myself all the time why God gave them such power to destroy me"*. Patients with traumatic memories have a fundamental impairment in their capacity to integrate traumatic experience with their life events; they show intense emotions or somatosensory impressions, which occur when they are aroused or exposed to trauma. These intrusions of traumatic memories can take different shapes: flashbacks, intense emotions, somatic sensations, nightmares, interpersonal re-enactments, character style, and pervasive life themes (Zepinic, 2008).

Because of timeless and unintegrated nature of traumatic memories, the treatment resistant patients remain embedded in the trauma as a contemporary experience, instead of being able to accept it as secondary that belongs to the past. The meaning of traumatic experience evolves over time, and often includes feelings of ir retrievable loss, anger, betrayal, and helplessness. Often any triggering factor interferes with traumatic growth and can activate long-forgotten memories of the trauma event(s), and create a 'domino-effect'. A person who was not previously bothered by intrusive and distressing traumatic memories may, after exposure to another event, re-experience memories of the previous trauma.

## 6. DIFFICULTIES TO APPROACH

It is well known that PTSD, as a form of trauma-induced psychiatric disorder, is more severe and longer lasting when it appears as a consequence of human destructiveness, such as torture or severe violence. The patients, who were tortured, internally displaced and later arrived in another country as refugees, often have experienced 'trauma-after-trauma' syndrome (Silova, et al., 2002; Zepinic, 2011). It is difficult to say whether the future for these people may be even harder than their past. By the time the severely traumatised individuals received any treatment, their 'trauma-after-trauma' syndrome is a continued trauma that could be portrayed by the five 'D's': (a) dehumanisation – to deprive of positive human qualities (inability to establish new friendships, communicate, socialise), lacking in personal warmth and respect (privacy, courtesy); (b) disintegration of the psyche integrity, wholeness, and cohesion during the war trauma; (c) dispossession of living place, occupation, family, and country; (d) dislocation – to live and exist as fugitives or refugees in foreign and unfamiliar places; and (e) disempowerment – involving the loss of their educational, linguistic, cultural, and occupational tools (Zepinic, 2010b).

Clinical experiences clearly have shown that many war-related PTSD patients had some initial response to the therapy but after some time they became 'deadlocked' in their progress. Such partial responders initially became non-responders as their treatment time passed by (those who showed little or no improvement with a treatment). The clinician usually tries to alter treatment approach but if further failure occurs it is evidently a treatment resistant case. This may cause further deterioration of one's PTSD symptoms making symptoms more severe and complex than they were prior to the commencement of treatment. Every clinician who treats chronic (complex) PTSD patient is aware of this hazard, particularly if trigger factors exist (flashbacks phenomena) which remind patient of the original trauma.

In clinical practice of treating the chronic (complex) PTSD patients, there is quite often unanswered question whether PTSD is a single disorder or a syndrome of few psychiatric disorders also accompanied with general medical symptoms? There are many *pros* and *cons* but in general this dilemma is particularly present within the severely tortured people. Many epidemiological studies (Allen, 2005; Axelroad et al., 2005; Boon, 1997; Branscomb, 1991; David et al., 1999; Oguendo et al., 2005; Zepinic, 2001) demonstrate that the severity of the torture causes development of other psychiatric diagnoses (than PTSD) such as a depressive disorder, anxiety disorder, personality disorders, psychosis, substance abuse, or somatisation disorder.

Davidson et al., (1991) found that those diagnosed with chronic PTSD more likely to report physical complaints than those without PTSD. Breslan et al. (1991) found that 83% of patients with PTSD also had some other psychiatric disorders. These findings should also be considered when a clinician faces treatment resistant PTSD. Individuals exposed to the severe trauma often develop other debilitating problems including impairments in physical health and in social and/or occupational functioning.

There could also be other contributing factors: poor social support, marital difficulties, occupational problems, etc. that can lead to the treatment resistant condition. Clinical experiences found that PTSD patients with a history of physical abuse while being tortured often complain of pain in different anatomical areas (gastrointestinal, headaches, psychogenic seizure, and spasm) very seriously despite not having evidence of any significant injury, or clinical test confirming no any evidence of physical symptoms existence.

Initial assessment with PTSD patient reveals the commonly reported symptoms: nightmares, flashbacks phenomena, memory problems, sense of foreshortened future, and detachment from others. Tortured individuals show forgetfulness, poor academic achievement, impatience and irritability, and inability to recall the event. They have many unanswered questions of the clinician and themselves. They usually ask "*What can I do in the future?*" or make a statement "*I feel I am not normal and I cannot go back to being normal... I will never feel happy again*". Patients are telling the truth, realistically saying that back to normal is very long way. They are pessimistic even with a help from provided treatment. Their daily functioning is often sufficiently affected and restricted.

They report destruction of desire, destructive sense of the self-continuity, values, ideas, things, and activities. There is evident loss of self-respect and loss of energy for living, and alienation from valued images. Even so, the value of possessions and sense of satisfaction can be lost. Relationships, love or friendships become extraordinary difficult and unstable, or they are unable to assume any kind of the occupational involvement.

There is a hostile or mistrustful attitude towards the world, detachment, feelings of emptiness and sense of hopelessness, chronic feeling of being 'on the edge'. They feel powerless, as if they had been used as pawns. The patients show feelings of worthlessness, dehumanisation, with very poor eye contact during therapy. They often report shame and guilty feelings, and exhibit alienation, cynicism, hypersensitivity to perceived injustices, and distrust of authority figures and public institutions. There are often common signs of mental or physical preparation for a danger as many of them will report to continue sleep on the same way they did in cell facing the door or window and 'being ready for a torture'.

Two cluster symptoms that occur more frequently in treatment resistant PTSD are: intrusive memories and avoiding thoughts of torture. There are few situations that implicate development of the treatment resistant PTSD: reluctance to talk and express feelings, presence of negative emotions, and posttraumatic growth. Patients avoid talking about the torture particularly in the early stages of therapy. It is also a huge dilemma for the clinicians to obtain some details about the trauma. Without any doubt, it is an ambivalent situation: the clinician needs to see patient's response to the trauma memories but at the same time patient can be 'exposed' to re-trauma while reporting his associated feelings. This risk is very common in clinical practice with patients who were victims of violence, rape, or torture.

For a clinician it might be appropriate to note in non-judgmental way awareness of the fact that the patient does not find it is easy to talk about what happened. The clinician should explore trauma-related thoughts and feelings without risk of causing re-trauma. This is much easier way in late phases of the therapy than in the beginning. A spontaneous clinician's approach will make the patient more comfortable talking about the traumatic experience (Allen, 2005; Courtois and Ford, 2009; Zepinic, 2011).

PTSD patients who were exposed to severe torture report intense negative emotions and fear, despair, sadness, and hopelessness. This is an accumulated trauma process that cannot be removed easily. Posttraumatic growth is a slow and gradual process. Congruent reintegration of the self and traumatic experience is not a simple way to return to pre-trauma levels of functioning, but about going beyond previous levels of functioning. It is common that the traumatic event shatters basic assumptions of the self and the world followed by intrusive and avoidant experiences (Bremner, 1997; Courtois & Ford, 2009; Ford, et al, 2005; Herman, 1992; Wilson & Drozdek, 2004). Breakdown and disorganisation of the self-structure and its cohesion manifested as an experience of incongruence is awareness that requires reintegration of the self.

## 7. WHAT WE CAN DO?

How to overcome the treatment resistant PTSD? The clinician should use various ways to make 'real contact with' and endeavours congruent, emphatic and unconditional positive regards for the patient. The patients will likely feel more comfortable talking about the traumatic experience when a good relationship has developed and they feel accepted and understood by the clinician. A trusting relationship, that should be encouraged and facilitated, is a key and crucial point in treating the PTSD.

When a patient starts to talk about the trauma and associated feelings the clinician should not direct the content of the narrative but analyse the outcomes of the trauma. It is a clinician's role to show re-assurance and understanding of the trauma-related difficulties and to stay with the patient's experience. As the patient explores the meanings of the traumatic experience, the clinician should transfer meanings into positive levels supporting patient's re-evaluation.

During the therapy it is necessary to follow 'process of change' and to relate the directions of change to the concept of motivation and condition of the self-worth. It is very important for the clinician to have a reasonable knowledge of PTSD literature in general. However, it does not mean that the general knowledge necessary applies to each and every patient. The clinician should not assume 'coping approach' but use a qualitative and idiographic individual approach to each patient, finding differences valuable alongside.

To fully understand damages on personality associated with the trauma, it is necessary to know various types of the patient's suffering (pain); to learn how fragmentation, dissolution, dissociation, fracturing, and diffusion of the self, identity, and ego processes occur and reconfigure following allostatic changes within the psyche. Trauma impacts the psychic core of the soul of the survivors and generates a search for meaning as to why the event(s) had to happen (Courtois, 2004; Ford, et al, 2005; Horowitz & Zilberg, 1983; van der Kolk, et al, 2005; Zepinic, 2010b, 2011). The trauma may lead to a de-centering of one's self, loss of groundedness and a sense of sameness, self-fragility, leaving scars on one's 'inner agency' of the psyche.

The posttraumatic growth of the traumatised self is based on three main domains: (a) changes in the perception of self, (b) changes in the experience of relationship with others, and (c) and changes in one's general sense of purpose (Zepinic, 2010b). In clinical practice with severely traumatised individuals there is often a clear presentation of the wane, loss, diminishing, and destruction of important relationships with a decreased sense of compassion and a critical view toward the others. They need a greater sense of intimacy, closeness, and free to be again 'a self', having desirable motivation to restore their own self strangled by the traumatic experience.

The main aims while providing the psychological therapy should be (a) the restoration of a form of relatedness (interconnectivity), (b) the restoration of a sense of aliveness/vitality (dynamism), and (c) the restoration of an awareness of self and inner events (insight). While implementing the above stated therapeutic aims, the therapeutic framework of Dynamic Therapy (Zepinic, 2010b, 2011) should include the 'C' concepts: connection, creativity, compassion, coping, contingency, co-construction, complexity, cohesion, and consciousness.

## REFERENCES

- Allen, J. G. (2005). *Coping with trauma* (2<sup>nd</sup> edition), American Psychiatric Publishing, Washington DC.
- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders – DSM-IV-TR*, Washington DC.
- Archibald, H. C., & Tuddenham, R. D. (1965). Persistent stress reaction after combat. *Archives of General Psychiatry*, 12, 475-482.
- Axelroad, R. S., Morgan, A. C., Southwick, M. S. (2005). Symptoms of posttraumatic stress disorder and borderline personality disorder in veterans of operation desert storm. *American Journal of Psychiatry*, 162, 270-275.
- Boon, S. (1997). The treatment of traumatic memories in DID: Indications and contra-indications, *Dissociation*, 10, 65-79.
- Branscomb, L. P. (1991). Dissociation in combat-related posttraumatic stress disorder. *Dissociation*, 4, 13-20.
- Bremner, J. D. (1997). *Trauma, memory, and dissociation*. American Psychiatric Association, Washington DC.
- Bremner, J. D. (1999). Acute and chronic responses to psychological trauma: Where do we go here? *American Journal of Psychiatry*, 156, 349-351.
- Bremner, J. D., & Brett, E. (1997). Trauma-related dissociative states and long-term psychopathology in posttraumatic stress disorder. *Journal of Traumatic Stress*, 10, 37-49.
- Breslan, N., Davis, G. C., & Andreski, P., et al. (1991). Traumatic events and posttraumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry*, 48, 216-222.
- Briere, J., Spinazzola, J. (2005). Phenomenology and psychological assessment of complex posttraumatic stress, *Journal of Traumatic Stress*, 5, 401-412.
- Brown, R., & Kulik, J. (1977). Flashbulb memories, *Cognition*, 3, 73-99.
- Courtois, A. C. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training*, 41, 412-425.
- Courtois, A. C., & Ford, J. D. (2009). *Treating complex traumatic stress disorder*. Guilford Press, New York.
- David, D., Kutcher, G. S., Jackson, E. I., & Mellman, T. A. (1999). Psychotic symptoms in combat-related posttraumatic stress disorder, *Journal of Clinical Psychiatry*, 60, 29-32.

- Davidson, J. R. T., Hughes, D., & Blazer, D., et al. (1991). Posttraumatic stress disorder in the community: An epidemiological study. *Psychological Medicine*, 21, 713-721.
- Ford, J. D., Courtois, A. C., Steele, K., van der Hart, O., & Nijenhuis, E. R. S. (2005). Treatment of complex posttraumatic self-dysregulation. *Journal of Traumatic Stress*, 5, 437-447.
- Frueh, C. B., Turner, M. S., Beidel, C. D., Mirabella, F. R., & Jones, J. W. (1996). Trauma management therapy: a preliminary evaluation of a multicomponent behavioural treatment for chronic combat-related PTSD. *Behaviour Research and Therapy*, 34, 533-543.
- Herman, J. (1992). *Trauma and recovery*. Basic Books, New York.
- Horowitz, M. J. (2001). *Stress Response Syndrome* (4<sup>th</sup> ed.). Jason Aronson Inc., New York.
- Horowitz, M. J., & Zilberg, N. (1983). Regressive Alterations in the self concept, *American Journal of Psychiatry*, 140, 284-289.
- Kardiner, A. (1941). *The traumatic neurosis of war*. Hoeber, New York.
- Marmar, R. C., Weiss, S. D., Schlenger, E. W., & Fairbank, A. J., et al. (1994). Peritraumatic dissociation and Posttraumatic stress in male Vietnam theatre veterans. *American Journal of Psychiatry*, 151, 902-907.
- Friedman, M. J. (1997), Posttraumatic stress disorder. *Journal of Clinical Psychiatry*, 58, 33-36.
- McNally, R. J., Lasko, N. B., Macklin, M. J., & Pitman, R. K. (1995). Autobiographical memory disturbance in combat-related posttraumatic stress disorder. *Behaviour Research and Therapy*, 33, 610-630.
- Mollica, R. (1988). *Post-traumatic therapy and Victims of Violence*, Brunner-Mazel, New York.
- Morina, N., & Ford, J. D. (2008). Complex sequelae of psychological trauma among Kosovar civilian war victims. *International Journal of Social Psychiatry*, 425-436.
- Oguendo, M., Brent, A. D., Birmaher, B., Greenhill, L., et al. (2005). Posttraumatic stress disorder comorbid with Major Depression: Factors mediating the association with suicidal behaviour. *American Journal of Psychiatry*, 162, 560-566.
- O'Toole, B. I., Marshall, R. P., Schureck, R. J., & Dobson, M. (1999). Combat, dissociation, and posttraumatic stress disorder in Australian Vietnam veterans, *Journal of Traumatic Stress*, 12, 625-640.
- Silove, D., Steel, Z., McGorry, P., Miles, V., & Drobny, J. (2002). The impact of torture on posttraumatic stress symptoms in war-affected Tamil refugees and immigrants, *Comprehensive Psychiatry*, 43, 49-55.
- Southwick SM, Morgan CA, Nikolaou AL, Charney DS: Consistency of memory for combat-related traumatic events in veterans of Operation Desert Storm, *American Journal of Psychiatry*, 1997, 154, 173-177.
- Tennant, C. C., Goulston, K. J. (1986). Dent OF: The psychological effects of being a prisoner of war: forty years after release. *American Journal of Psychiatry*, 143, 618-621.
- Shalev, A.Y., Freedman, S., Pery, T., & Brandes, D., et al. (1998). Prospective study of Posttraumatic stress disorder and Depression following trauma. *American Journal of Psychiatry*, 155, 630-637.
- van der Kolk, B. A., Herron, N., & Hostetles, A. (1994). The history of trauma in psychiatry, *Psychiatric Clinic of North America*, 1994, 17, 583-600.
- van der Kolk, B. A., Ruth, S. H., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorder of extreme stress, *Journal of Traumatic Stress*, 18, 389-399.
- Wilson, J. P., & Drozdek, B. (Eds.). (2004). *Broken Spirit*. Routledge, New York.
- Zahava, S., Neria, Y., Ohry, A., Waysman, M., Ginzburg, K. (191914). PTSD among Israeli former prisoners of war and soldiers with combat stress reaction: a longitudinal study. *American Journal of Psychiatry*, 151, 554-559.
- Zepinic, V. (1997). Psychosocial characteristics of war-related Posttraumatic stress disorder (Chapter 10). In B. Ferguson & D. Barnes (Eds.), *Perspectives on Transcultural Mental Health*, TCMHS, Sydney.
- Zepinic, V. (2001). Suicidal risk with war-related Posttraumatic stress disorder (Chapter 14). In B. Raphael & A. E. Malak (Eds.), *Diversity and Mental Health in Challenging Times*, TCMHS, Sydney.
- Zepinic, V. (2008). Healing traumatic memories: A case study. *Dynamische Psychiatrie*, 5-6, 279-287.
- Zepinic, V. (2010a). Defining a war-related psychological trauma: Is that an impossible task? *The International Journal of Medicine*, 3, 376-383.
- Zepinic, V. (2010b). Treating the war-related complex trauma using Dynamic Therapy, *The International Journal of Medicine*, 3, 384-390.
- Zepinic, V. (2011). *Hidden Scars: Understanding and Treating Complex Trauma*. Xlibris, London.
- Zepinic, V. (2012). *The Self and Complex Trauma*. Xlibris, London.