

LANGUAGE, CULTURE, COMMUNICATION

WORKING WITH TRAUMA IN DIALECTICAL BEHAVIORAL THERAPY: LITERATURE REVIEW

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Summary

Modern society sees that war is becoming a permanent phenomenon. The consequences of war are always injuries of a physical and mental nature. The article focuses on the experience of a traumatic personal experience. The main diagnostic criteria for making a diagnosis of trauma are highlighted. The aim of this review is to discuss the theoretical and empirical evidence that examines the potential effectiveness of dialectical-behavioral therapy in working with the traumatic experience of an individual, as a way of building a theoretical model of working with trauma in DBT. The author's model in working with trauma is considered, which is based on a dialectical-behavioral approach and contains the following components: balancing self-awareness, balancing consciousness, acceptance and actions of the individual, balancing with the help of adaptation, balancing thinking, balancing emotions, balancing relationships, harmonizing, and supporting the individual. In the theoretical and practical context, the essence of leading strategies in work with trauma is disclosed. The main dialectical contradiction of psychological trauma is the internal conflict between erasing everything from memory and the desire to share with someone.

Key words: trauma, dialectical behavior therapy (DBT), model of working with trauma, posttraumatic stress disorder (PTSD).

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1. Introduction

Today's wartime proves that the term "trauma" will be in the everyday and scientific lexicon of Ukrainians for a long time, and after the war, in the post-war period. A trauma is an event that has a strong impact on a person's mental and/or physical state. According to the American classification of mental disorders (DSM-V), trauma is considered in the context of post-traumatic stress disorder; that is, a person must have certain symptoms. Symptoms of the injury decrease during the first month in some of the victims. The rest develop various types of disorders that are associated with adaptation.

Understanding the consequences of trauma and determining the appropriate treatment for victims remains one of the most difficult and controversial tasks. Although it is known that cognitive-behavioral methods of treatment have the greatest empirical basis for the treatment of trauma.

Our interpretation of trauma symptoms has expanded to include the knowledge that outcomes associated with traumatic experiences are not limited to the posttraumatic experience but rather extend to a range of intrapersonal and interpersonal problems. However, the history of trauma still leaves gaps in the treatment of a wide range of problems that are related to trauma.

2. Main text

In our scientific explorations, we will rely on therapeutic studies conducted by the founder of the dialectical behavioral method Linehan (1993). The concept of "mental trauma" became the most widespread in the theory of post-traumatic stress disorder and crisis psychology in the 1980s. As noted by researchers, the most common causes of mental trauma are the presence of a chronic incurable disease, loss, disasters, divorce, humiliation, bullying, and physical trauma (Reutter, 2019; Herman, 2020; Raja, 2012; Bohus, 2013; 2019; 2020; 2021; Landes, 2013; Sweezy, 2011, and Van der Kolk, 2015). Trauma is an extreme event that causes a person to act in an extreme way. After an injury, a person feels that all spheres of life are out of balance.

A trauma survivor has unmet needs. As noted by Maslow (1943), when a person has unsatisfied needs, the following principles are triggered: the mind focuses on unmet needs, not on achieved ones; when it is not possible to achieve many needs, the brain focuses on lower needs.

Herman (2015) points out that the central dialectical contradiction of psychological trauma is the conflict between the desire to forget the terrible event and the desire to talk about it. A single traumatic situation can happen anywhere. A prolonged traumatic situation is inherent in the circumstances of captivity. The diagnostic criteria for trauma are quite broad given the limited nature of these events, as they are usually based on the experience of hostilities, rapes, and disasters. If we consider long-term repetitive trauma, the picture of symptoms is much more complex, namely changes in the structure of the personality, distortion of the person's identity and changes in relationships with others.

Trauma disrupts the balance in all areas of a person's life. Very often, trauma forces a person to make radical decisions. Trauma activates judgment and narrows behavioral options down to three: fight, run, or freeze. Although of course these three types of behavior are adaptive and necessary during a crisis, they are not effective in the long term. In contrast to this three-level model of behavior, there are skills of distress tolerance, which allow a person to learn to act in destructive situations in an ecological and safe manner.

When it comes to using coping strategies, it is important to remember to do so in a calm and stable state, and to be patient and tactful in using them. The leading psychological reactions of psychological trauma include shock, irritation, emotional instability, shame, feelings of helplessness, problems with concentration, feelings of anxiety, and fear. As for the physical reactions, these are, for example, sleep problems, rapid heartbeat, fatigue, agitation, tension in the body, and headaches.

Work with psychotrauma takes place in various psychotherapeutic directions, which have clinically proven effectiveness in trauma-focused therapy, EMDR, CBT. However, we turn our attention to dialectical behavioral therapy (DBT), which is one of the leading methods of the so-called "third wave" of cognitive-behavioral therapy.

The research of scientists dealing with trauma is primarily focused on highlighting several aspects:

1. Work with trauma in clinical therapeutic practice on the example of a small sample.
2. Description of DBT work technology with post-traumatic stress disorder.
3. Consideration of case customers, their comparison.

4. Use of statistically significant research methods (for example, quantitative and qualitative methods and case method).
5. The presence of childhood trauma in a person's anamnesis increases the development of PTSD.
6. Researched are usually young women and students.
7. Orientation to the implementation of DBT in state-sponsored medical treatment.

The lack of a single approach to trauma determines the scientific search and consideration of this issue. Trauma in most dialectical-behavioral studies is considered in the context of post-traumatic stress disorder, because of childhood trauma, abuse, family and sexual violence. It is also worth noting the lack of a clear division into types of trauma among modern scientists, since more emphasis is placed on the treatment and implementation of the DBT program and the PTSD work protocol.

Our scientific investigations contribute to the emergence of questions regarding the differentiation of trauma and its impact on the personality in the future. Can we talk about the specifics of trauma during military operations, child trauma, abuse, family violence, sexual abuse? Is there a difference in working with different types of trauma? Is the classic protocol for working with PTSD in DBT suitable for working with all types of trauma? Is the interpretation and understanding of trauma identical to post-traumatic stress disorder in dialectical behavior therapy.

We can say with confidence that in dialectical behavioral therapy, post-traumatic stress disorder is interpreted as a consequence of a traumatic experience, regardless of the types of trauma. However, in the studies we looked at, it concerned sexual violence, child trauma, and maltreatment.

In our psychological practice, we use the dialectical principle, that is, we combine acceptance and change. So, our theoretical model in working with trauma contains the following components: balancing self-awareness; balancing the consciousness, acceptance and actions of the individual; balancing through adaptation; balancing thinking; balancing emotions; balancing relationships; harmonization and support of personality. Let's consider each component in more detail.

A traumatic experience always throws a person out of balance. However, psychological science has developed a treatment model that aims to restore balance in consciousness, thinking, emotions and behavior of a person who has suffered trauma. This is dialectic-behavioral therapy. At the heart of this direction is a philosophical approach symbolized by the term "dialectics" and means the unity of opposites. That is, each of us can experience ambiguity, and this method helps to find a middle ground between, for example, excessive and insufficient, hyperemotionality and hyperemotionality, excessive excitement, and impulsivity. Dialectic-behavioral therapy helps to become self-aware, accept oneself and others, adapt to stress and trigger situations, regulate one's emotions and thoughts, and improve interpersonal relationships.

Imbalance primarily begins with consciousness. When experiencing a traumatic experience, it is worth paying attention to the manifestations of personality. The realization of the principle of self-awareness is possible by observing the following rules: recognition, permission, investigation and development. For example, recognizing the signs that person is angry and letting it come and go (clenching fists, etc.), find out the cause of this emotion and finally use new coping strategies that allow to control breathing, muscle relaxation and rest. This approach allows to move from the physiological level to the metacognitive one.

The mind of the individual produces thoughts and emotions. In dialectical behavior therapy, Marsha Linehan (1993) suggests balancing emotions and thoughts with the help of a wise mind, which performs several useful functions, including identifying our thoughts and feelings, evaluating them, allowing us to regulate emotions and thoughts, teaching us to make

balanced decisions. The life of an individual flows in several spaces: the physical, professional (activity), social and spiritual. Harmonization in these spaces is possible due to the even distribution of human forces and energy, because otherwise disproportions can lead to internal conflicts and deepening dissatisfaction.

Psychological trauma as a traumatic crisis is the result of a certain unpredictable and sudden event. This causes a violation of the regulatory organization of the psyche from a temporary feeling of discomfort to clinical conditions, with loss of work capacity and capacity for action.

The implementation of dialectical behavior therapy in the treatment of trauma shows not only its effectiveness but also its comparison with other types of therapy trauma-focused therapy.

Studies by Steil, Engelmann, Stangier, Priebe, Fydrichb, Weiß, and Dittmanna (2022) seem interesting, which aimed to develop a scale for assessing attachment and specific competence for the treatment of dialectical behavioral therapy of post-traumatic stress disorder (DBT-PTSD), as well as to study their psychometric properties. Global cognitive-behavioral therapeutic competence and disorder-specific therapeutic competence were assessed using existing scales to confirm their psychometric properties in a sample of patients with PTSD and emotion dysregulation. In our opinion, thanks to this kind of research, we can talk about adequate evaluation and effective use of DBT techniques in work with PTSD.

Meanwhile, Gratz, Berghoff, Richmond, Vidaña, Dixon-Gordon (2020) investigated the presence of post-traumatic stress disorder (PTSD) as a predictor of response to dialectical behavior therapy (DBT) treatment with primary outcomes representing interest in DPT. PTSD was associated with better response to measures of BPD symptom severity and a steeper (albeit small) reduction in PTSD symptoms over the course of treatment.

Alternatively, Xiao (2022) in his research focuses on the implementation of the DBT work evaluation model with traumatic experience following the genetic algorithm. As shown by the studies of the DBT scientist, the techniques help to eliminate the symptoms of PTSD.

Instead, scientists suggest testing and building feedback systems for trauma-related emotions. Because they can be used to differentially indicate emotion-related interventions (Görg, Böhnke, Priebe et al., 2019; Görg, Dyer, Steil, 2017).

On the one hand Ross (2005), researching personality disorders, notes that they are often concomitant and combine each other's symptoms. The use of dialectical behavioral therapy proves a positive effect on a person suffering from borderline disorder. At the same time, the model of trauma therapy for dissociative disorder is considered. The proposed psychotherapeutic treatment program seems interesting, which can help clarify the role of DBT in the treatment of not only borderline disorders but also dissociative disorders, for example.

On the other hand, Raja (2012) in her scientific applied work provides a detailed analysis of techniques and practices for working with different types of traumatic events, based on cognitive behavioral therapy, dialectical behavioral therapy, and acceptance and commitment therapy. At the same time, preference is not given to any one method of work. As the scientist notes, traumatic events include sexual violence, child abuse, domestic violence, murder, street violence, car accidents, war crimes, natural disasters, and fires.

Consider the complexity of the relationship between early traumatic experiences, feelings, coping strategies, and adult trauma. Childhood or adolescent trauma can be caused by a feeling of loneliness and abandonment, parental betrayal, which leads to a loss of trust in the outside world, a desire for isolation, and, accordingly, contributes to the expression of vulnerability. As for youth trauma and trauma in adulthood, it is usually accompanied by unhealthy strategies, for example, the use of psychoactive substances, avoidance of emotions, sexual

risk-taking behavior. Furthermore, in the adolescent period, accentuations of the character of the individual are clearly expressed, which also contribute to the manifestation of chemical and non-chemical dependencies (Geddes, Dziurawiec, & Lee, 2013).

Harned, Schmidt, Korslund, Gallop (2021) examined DBT with and without DBT PE in four public mental health facilities in a pilot nonrandomized controlled trial. There are no unequivocal results yet. Despite all the misgivings on the part of clinicians about the use of explosion therapy, that during the treatment of post-traumatic stress disorders with the help of this therapy there are often sudden improvements that have prognostic value (Krüger *et al.*, 2014). The scientists found that exposure-based treatment did not lead to a worsening of PTSD symptoms in the subjects.

Besides Becker and Zayfert (2001) learning the specifics of PTSD treatment in clinical settings. Researchers say that DBT can reduce the impact of external life stress that interferes with therapy by providing more effective coping skills. DBT also provides the patient with supportive skills to manage therapy-interfering emotions (e.g., anger, shame, guilt) and behaviors (e.g., dissociation, non-adherence). DBT helps interrupt secondary emotional responses that may be involved in perpetuating trauma-related distress. Ultimately, DBT skills increase the patient's ability to fully activate and attend to anxiety during exposure. As a result, clinical studies by scientists confirm that many "unsuitable" patients can both tolerate and benefit from exposure.

In dialectical behavioral therapy, work with trauma takes place according to the protocol. The following criteria are used:

- 1) the client cannot be in immediate danger of suicide;
- 2) the client has not attempted suicide or self-harming behavior within 2 months;
- 3) the client has the opportunity to recognize and experience signs of suicidal behavior without self-harming;
- 4) the client cannot use behavior that threatens and interferes with therapy;
- 5) the main priority in treatment should be to work through the post-traumatic experience and seek to heal;
- 6) the client must be ready to experience strong emotions and at the same time does not avoid strong experiences or emotions.

Bohus, Kleindienst, Hahn, Müller-Engelmann, Ludäscher, Steil, Fydrich, Kuehner, Resick, Stiglmayr, Schmahl, Priebe (2020) wrote about dialectical behavior therapy for posttraumatic stress disorder (DBT-PTSD) compared with cognitive processing therapy (CPT) in complex presentations of PTSD in women survivors of childhood abuse: A randomized clinical trial. Childhood abuse significantly increases the risk of developing posttraumatic stress disorder (PTSD), often accompanied by symptoms of borderline personality disorder (BPD) and other co-occurring mental disorders. Despite the high prevalence, systematic evaluations of evidence-based treatments for PTSD after childhood abuse are sparse. These findings support the efficacy of DBT-PTSD and CPT in the treatment of women with childhood abuse-associated complex PTSD. Results pertaining to the primary outcomes favored DBT-PTSD. The study shows that even severe childhood abuse-associated PTSD with emotion dysregulation can be treated efficaciously.

Also, the team of modern scientists (Bohus *et al.*, 2019), developed a dialectical behavioral therapy assessment program for the treatment of post-traumatic stress disorder in child victims of violence. According to this program, the following modules have been identified for work: pre-treatment, commitment, trauma-model and motivation, skills and cognitive elements, exposure techniques, radical acceptance, a life worth living, well-being.

In another scientific investigation led by Martin Bohus, et al. (2019) it is noted that post-traumatic stress disorder after childhood abuse is often associated with comorbidity, in particular with symptoms of borderline personality disorder. DBT-PTSD was developed under the direction of Bochas to meet the specific needs of patients with complex PTSD. The treatment program is based on the rules and principles of dialectical behavior therapy (DBT), and adds interventions derived from cognitive behavioral therapy, acceptance and commitment therapy, and therapy that focuses on compassion. DBT-PTSD can be provided as a comprehensive clinical program or as an outpatient program.

According to research Cornelisse, Biermann, Enning, Schmahl and Kleindienst (2021) conducted, post-traumatic stress disorder (PTSD) can be effectively treated in adolescents and young adults. However, there is a lack of studies investigating the effectiveness of psychotherapy in the clinically important group of adolescents with PTSD related to childhood sexual and/or physical abuse and concurrent symptoms of borderline personality disorder (BPD).

Steil, Dittmann, Müller-Engelmann, Dyer, Maasch, and Priebe (2018) wrote about another clinical trial of outpatient treatment for patients with post-traumatic stress disorder and previous sexual violence in childhood. Unequivocal results have not yet been established.

Instead, Wilkinson (2016) focuses on adolescent research based on the principles of DBT and an understanding of the different principles of information processing and learning associated with each of the A and C attachment strategies as understood in the dynamic model of adulthood.

At the same time, the probability of suicide remains high, especially among people who have experienced military actions. Substance use, post-traumatic stress disorder, and depressive symptoms are actualized and lead to suicidal manifestations. However, research on these models is not complete. Furthermore Landes, Garovoy, and Burkman (2013) describe the specifics of veteran trauma and various PTSD treatments. A common thread among these treatments (DBT, SS, STAIR Narrative Therapy) is their focus on structured, skill-based intervention that directly targets behaviors that create significant distress in veterans' lives (e.g., emotion regulation, impulsive behavior, self-view). Each model offers unique features, but also shares the common goal of working in Stage 1 to help stabilize clients across a wide range of complex PTSD symptoms. It is important to note that the researchers found that veterans were often victims of sexual violence and abuse during childhood and during their service in the military, which accordingly reinforces the flow of traumatic experiences.

A recent study by Cameron, Eaton, Brake, and Capone (2021) focuses on relationships between depressive symptoms, suicidal ideation, and distressing events in war veterans. The main objective of this study was to examine the impact of morally harmful events as a risk factor for suicide in veterans who use psychoactive substances. This acts to help the veterans escape from psychological stress.

According to the results of their study, it was found that the impact of morally harmful events and symptoms of depression were higher in participants with a diagnosis of PTSD, but there was no significant difference between those who had and those who did not have such a diagnosis in the use of psychoactive substances. In the context of the study, it was established that the trauma had a moral impact on the manifestation of suicidality.

One of the most recent studies in this direction is the scientific exploration Nagy, Pickett, and Hunsanger (2022). The researchers studied emotion regulation difficulties caused by trauma, PTSD symptoms, and sleep disturbances. Dispositional mindfulness, the tendency to be in the moment, with acceptance and non-judgment, was conceptualized as adaptive emotion regulation. As the researchers note, dispositional mindfulness is associated with adaptive

posttraumatic outcomes, but has not been studied in the context of sleep disturbance. This study aimed to extend previous research to examine the relationship between dispositional mindfulness and trauma outcomes. As evidenced by the results of the study, dispositional mindfulness is associated with a lower frequency of PTSD-related sleep disturbances and better sleep quality (daily disturbances). It was also established that specific components of dispositional mindfulness remain significant when components of emotion regulation difficulties are included in the model.

Several years ago, mental health researchers made a series of breakthroughs in the treatment of trauma. For example, treatment of post-traumatic stress disorder with the help of cognitive-behavioral therapy demonstrates a reduction in PTSD symptoms and restoration of functioning. Cognitive-behavioral therapy is based on learning theory, so treatment from this perspective involves learning new ways of interacting and coping with painful thoughts and feelings. As has been noted dialectical behavioral therapy techniques will be helpful for people who suffer from emotional dysregulation, who want to improve their interpersonal relationships and feel personal security. DBT is based on mindfulness practices. Through mindfulness, one becomes able to focus on a goal or intention and is able to be attentive without judgment. At the same time, the dialectical-behavioral approach to the interpretation of mindfulness differs from the cognitive-behavioral approach, namely: 1) DBT emphasizes the awareness of inner experience and the use of “wise mind”; 2) the practice of mindfulness in any behavior is encouraged, which is different from meditation, which is not required, which is why mindfulness is fully integrated into an individual's daily life (Follette, Briere, Rozelle, Hopper, & Rome, 2015, p. 77)

Following this Choi-Kain, Wilks, Ilagan, Iliakis (2021) in their research note that borderline personality disorder with post-traumatic stress disorder is severe consequence of early trauma that leads to a person's disability. These scientists note that the use of exposure therapy will be more effective when the trauma is already in the past, and not ongoing. Therefore, working with patients involves creating safe conditions for understanding the trauma as part of the past, as a necessary component for optimal recovery after intensive DBT therapy.

Although earlier Foa, Hembree, and Rothbaum (2007) proposed a program based on prolonged exposure (PE) therapy, the primary goal of which is to help trauma survivors focus emotionally on sensations while reducing PTSD symptoms. This program is intended for teenagers and includes the following procedures: motivational interview to improve attendance and treatment; case management to eliminate obstacles in therapy; teaching general reactions to a trauma; training in breathing techniques; conducting in vivo experiments with situations or objects that the client avoids and feels anxious and afraid of; repeated long-term presentation of traumatic memories, images; review of treatment and prediction of future reactions and situations.

At the same time, the founder of the DBT method, Marsha Linehan (2015), notes that initially when working with a clients' traumatic experience, it was important to teach them effective problem-solving strategies. However, it was not easy, because the client was required to make very difficult changes in own life. The scientist notes that often clients responded with hostility, aggression or refused further treatment. Therefore, treatment strategies have changed and focused on acceptance and warmth. This required the therapist to begin using new strategies that encompassed synthesis, including:

- 1) techniques of change and techniques of acceptance;
- 2) the therapist's understanding of the direction of movement, taking into account the speed and flow;

3) the use of radical acceptance by the therapist in relation to his client, despite his rate of progress and risk of suicide;

4) humility of the therapist to see the transactional nature of the surrounding reality. This reflects the synthesis of acceptance as well as changes in acceptance of the client in the place where he is. At the same time, several change strategies aimed at solving problems, acceptance strategies with an emphasis on verification and validation of the individual are used.

However, synthesizing acceptance and change causes anxiety among clients. Given the complexity of clients' problems, asking the therapist to temporarily tolerate a distressing experience in order to focus on other goals of treatment is quite a difficult, if not impossible, task. For many clients, experiencing memories and feelings is unbearable and provokes dysfunctional behavior. Ms. Linehan proposed a new set of goals for clients who focus on learning: 1) the radical acceptance that each person must accept their past, present and realistic limitations regarding the future; 2) develop skills to tolerate distress without impulsive or destructive reduction. Dialectical behavioral therapy is fundamentally based on behaviorism, and at the same time when DBT was created, behavioral treatments focused primarily on changing the distressing experience, not on temporarily tolerating it. This was the reason for the change in traditional behavioral treatment.

DBT specialists proposed a hierarchy of procedures for how and what to treat a specific client. For the clinician, this is a wonderful opportunity to treat people with a variety of problems and challenges. Accordingly, the goals are grouped into recommended stages of treatment. At the first stage, the client's condition is stabilized and control over own behavior is achieved. At this stage, the following behavioral goals are distinguished: to reduce behavior that poses a threat to a person's life (suicidal manifestations, self-harm), to reduce behavior that interferes with therapy (e.g., refusal to cooperate, provocation of the therapist,), to reduce behavior that affects the quality of the client's life (e.g., use psychoactive substances, unemployment, homelessness), increase the manifestations of skillful behavior (with the help of skills training). The second stage is called the stage of "quiet despair", that is, the individual controls his actions, but emotional experiences – not. In stage 2, the goal of treatment is for the client to experience the full range of emotions. Post-traumatic stress disorder is treated at this stage. The third stage consists in reducing the usual problems in life. Stage 4 is designed to enhance a sense of wholeness, find joy, and/or achieve transcendence. Different strategies can be used at each stage. For example, dialectical strategies: balancing between acceptance and change strategies, paradoxical intervention (changes versus acceptance), use of metaphors, devil's advocate, extending; validity strategies module: pay attention, reflect, monitoring one's own emotions and states, understanding the causes, acknowledge the inherently valid feelings, with equality and authenticity; problem solving strategies module: behavioral assessment, contingency management procedures, skills training procedures, exposure procedures.

So, as we can see, there is a wide range of techniques and strategies that help to ecologically experience disturbing events and circumstances. It is worth understanding that the behavioral direction of therapy is focused on changing behavior, and the dialectical-behavioral direction teaches tolerance, the ability to accept and find meaning and experience distress. In particular, the skills of radical acceptance became especially relevant in the scientific space after the publication of the terrible stories of the Nazi concentration camps. Radical acceptance of the facts of the present moment is essential for survival. Distress tolerance training teaches self-soothing techniques aimed at getting through a crisis without making the situation worse (e.g., not using psychoactive substances, avoiding suicide attempts or other dysfunctional behaviors). Distress tolerance is a set of skills that are aimed at accepting reality, reducing suffering, increasing freedom when painful facts cannot be changed immediately or at all.

Recent studies demonstrated that the use of both cognitive and emotional client appeals was effective in reducing clinician anxiety and increasing positive beliefs about exposure therapy in general (Farrell, Deacon, Dixon, and Lickel, 2013). A traumatic experience requires complete focus on processing its manifestations, symptoms and signs. In the dialectical-behavioral approach, the possibility of processing the trauma occurs in the context of DBT work of the team, if there is none, then individual therapy is used, but it will work better in combination with telephone coaching, skills training, and group therapy. Another point is that treatment is time-consuming and may exceed the available resources of both the client and the clinician. For the client, the amount of treatment may be too much of a commitment.

In research (Landes, Garovoy, & Burkman, 2013) note that complex trauma (especially among veterans) is an urgent problem given the turbulent realities of today. A few methods are highlighted that are effective in working with such experience. In fact, there are many challenges in treating veterans, and the distress associated with PTSD symptoms is a result of exposure to complex trauma. High levels of distress associated with difficulties in affect regulation (suicidal thoughts, actions) may lead to treatment that focuses exclusively on crisis management. Symptoms of trauma can make it difficult to participate in psychotherapy, given the low level of self-regulation and self-control. Dialectical behavioral therapists in their recent scholarly work notes that clinicians may have trouble distinguishing between psychopathology, traumatic experience, and emotional dysregulation while using the correct chronic exposure protocol (Harned, 2022; Wagner, Rizvi, & Harned, 2007).

3. Conclusions

Thus, even though dialectical behavior therapy was developed to work with borderline clients, it has proven itself well in working with PTSD. Dialectical behavioral therapy in working with trauma is enhanced by the following factors:

- use of emotion and behavior management skills that interfere with personality healing (e.g., shame, guilt, attachment);
- DBT techniques help to split the secondary emotions that were involved in experiencing the trauma;
- DBT skills increase the individual's ability to fully activate and pay attention to their states during contact.

It is also worth noting that working with strong emotions involves the ability of a person to withstand this contact. Using a dialectical behavioral psychotherapy approach to trauma treatment, it is important to note that their focus is on structured interventions based on skills that directly address behaviors that create significant distress in the life of the traumatized individual, which may manifest in, for example, impulsive behavior and emotion dysregulation. Thus, this dysfunctional behavior interferes with the successful engagement and application of psychological treatment methods. The primary priority is to stabilize the client during a wide range of complex PTSD symptoms.

The specifics of experiencing trauma in a cross-cultural context remain interesting and unexplored. Culture is an integral part of all relationships. Our cultural context shapes perceptions, attributions, perceptions of ourselves and the world around us. It is the incredible influence of culture that permeates all aspects of human life, which is often unknown to us. We are all multicultural in the sense that we belong to many subcultures at the same time. For example, a young soldier who has returned from a combat zone belongs to a military culture that values victory, following orders, and courage. However, he may return to a society where the war in which he fought

is not valued, and this is when the clash of value orientations of the individual and society begins. At the same time, he may be a member of an organization or community where open expression of emotion, vulnerability, or sensitivity is sanctioned or frowned upon. He may belong to a certain subculture that promotes struggle and at the same time a member of a religious community, which adds another layer to his cultic profile of experiencing the surrounding reality.

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