BRAIN. Broad Research in Artificial Intelligence and Neuroscience
ISSN: 2068-0473 | e-ISSN: 2067-3957
Covered in: Web of Science (WOS); PubMed.gov; IndexCopernicus; The Linguist List; Google Academic; Ulrichs; getCITED; Genamics JournalSeek; J-Gate; SHERPA/RoMEO; Dayang Journal System; Public Knowledge Project; BIUM; NewJour; ArticleReach Direct; Link+; CSB; CiteSeerX; Socolar; KVK; WorldCat; CrossRef; Ideas RePeC; Econpapers; Socionet.

2024, Volume 15, Issue 1, pages: 46-58 | https://doi.org/10.18662/brain/15.1/535

Posttraumatic Stress Disorder: The Lighthouse at the End of the World and the boy who searched for the light

Mioara GRIGORAŞ[1]
Anamaria CIUBARA[2]

[1] Psychologist, Private Practice, Galaţi, România
[2] University Proffesor Phd, "Dunarea de Jos" University of Galaţi, Galaţi, România

Abstract: *Defining the word "trauma" is a delicate and difficult challenge, but I think it is very important to include the word trauma in our vocabulary. Generally, when we think of the word trauma, most of us associate it with a catastrophic event. However, it can apper into our lives and disrupt the proper functioning of our mind, body and soul generated by even "smaller" events. The difference is made by everyone's degree of resistance to stress.*
It is also very important to use the word trauma in a way that is as conscious as possible, but also correct.
The studies tell us very clearly, starting from Sigmund Freud's Era, that you cannot overcome, you cannot improve, you cannot heal something that you cannot express in words. Trauma is the effect or the produced by an event or an experience in our inner universe. It is a form of disconnection from one's own person, from one's own story and most often from one's own body.
While the causes and symptoms of trauma are various, there are some basic signs. People who have been through traumatic events will often appear shaken and disoriented and may often seem withdrawn or absent even when speaking.
Another clear sign of trauma is the anxiety (night terrors, nervousness, irritability, poor concentration and mood swings).
Trauma often manifests itself both emotionally and physically.
The emotion motion is one of the most common ways trauma manifests itself. Some common emotional symptoms of trauma include denial, anger, sadness, and emotional outbursts , anxiety or panic attacks.
Some common physical signs are: paleness, lethargy, exhaustion, poor concentration, and rapid heartbeats.
The effects of trauma can occur either in a short period of time after the event has taken place or in weeks or even years. The earlier the trauma is addressed, the more successful the person will be in the recovery process.
We all go through scary situations at some point, but we all react differently. If a person cannot get over the traumatic event and his feelings about the experience remain present or worsen as time goes on, he might suffer from Post Traumatic Stress Disorder.
Sometimes when we go through an extremely terrifying or chronically stressful experience, the brain overestimates the danger and our stress systems malfunction.
When this happens, different areas of the brain begin to make mistakes as they interpret the world around them and tell the rest of the body how to respond.
PTSD is associated with problems in the brain structures and neurotransmitters (the brain's chemical messengers) that are responsible with the way we respond to fear and stress.
The word trauma can really scare us, but there is also healing.
But healing is not guaranteed, according to Gabor Matte,but it is available and it depends only on our freedom to choose what we do next.
What does trauma recovery mean?
It's about reclaiming our healthy parts, reclaiming the external reality as a benchmark and reclaiming our ability to acknowledge the pain from the past, allowing it the right to exist in present context.

Keywords: *trauma, posttraumatic stress, traumatic exposure.*

How to cite: Grigoraş, M., & Ciubara, A. (2024). Posttraumatic stress disorder: the lighthouse at the end of the world and the boy who searched for the light. *BRAIN. Broad Research in Artificial Intelligence and Neuroscience, 15*(1), 46-58. https://doi.org/10.18662/brain/15.1/535

Introduction

Post-traumatic stress research began immediately after World War II. All descriptions of this phenomenon always included a number of common elements: sleep disturbances, nightmares, depressions, increased excitability.

Over time, post-traumatic stress has been named in several ways by different authors, through the phrases "railway syndrome", "soldier's heart", "stress reaction syndrome", "emotional neurosis", etc (Levine, 2020).

It was not until 1980 that the term Posttraumatic Stress Disorder (PTSD) was formalized, being published in DSM-III.

DSM-IV-TR (APA, 2000) includes Posttraumatic Stress Syndrome in the anxiety syndrome, and DSM-V includes Posttraumatic Stress Disorder (PTSD) in the Trauma and Other Stressors category (Bovin et al, 2015).

This category includes disorders in which an adverse event, traumatic or not, precedes the mental disorder. According to the DSM-V (Diagnostic and Statistical Manual of Mental Disorders), Posttraumatic Stress Disorder (PTSD) is primarily characterized by an individual's exposure to a catastrophic, traumatic event that exceeds their ability to cope with the traumatic situation (Levine, 2022).

The 5th edition of the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, defines PTSD as consisting of four categories of symptoms (DSM-5, 2013):

1. Continously living the events: the spontaneous appearance of images related to the traumatic event, repeated dreams, so-called flashbacks or other stressful, repeated, prolonged mental manifestations;

2. Avoidance: refers to the avoidance of stimuli associated with the traumatic event, thoughts, emotional states or external stimuli that remind of the trauma;

3. Negative thoughts or mood: refers to emotions ranging from a stable, lasting, distorted feeling of self- or others' culpability to alienation from others, a marked decrease in interest in daily activities that used to produce pleasure to the inability to remember key aspects of the traumatic event;

4. State of hypervigilance, hyperexcitation - the person suffering from PTSD reacts aggressively and quickly to external stimuli, generating sleeping disorders

PTSD involves a complex clinical presentation with a wide range of trauma-related symptoms. Multiple comorbid problems such as depression, anxiety, and substance abuse can occur with an irreversible evolution if they

are not treated and can cause extensive impairment in social or occupational functioning (Izzat et al, 2021).

Establishing a diagnosis of PTSD according to DSM-V requires determining that a person has been exposed to a traumatic event (Criterion A), has the required number of symptoms from each group (Criteria B – E), has a duration of symptoms of at least a month (Criterion F) and presents a clinically significant deficit in the social and professional sphere (Criterion G) (Luca et al., 2022).

Techniques and methods

During the 18 therapeutic sessions, the methods and techniques used were structured on three levels: symptomatological, existential and transgenerational:

- active listening, reflection techniques, body awareness, affective and relational awareness - Empty chair technique; I am..Technique.; mindfulness techniques; of body relaxation-Jacobson and abdominal breathing; guided imaging; prescriptions from cognitive-behavioral therapy (the A B C depression model, monitoring affective states, the list of preferred occupations, focusing the client's interest on the psycho-affective comfort zone); grounding techniques; desensitization through exposure-memories, feelings, cognitions; expressive-creative means.

For the psychological evaluation, in addition to the clinical interview, history, study of the medical file, behavioral observation, the following psychological tools were applied (Brady et al., 2000; Bisson et al., 2007):

- PDSQ questionnaire – psychiatric screening: to obtain high/elevated scores on the following scales: Posttraumatic Stress Disorder, Panic Disorder scale, Generalized Anxiety Disorder scale, Depressive Disorder scale, Somatization Disorder scale).

- Cognitive-Emotional Coping Questionnaire (CERQ) - significantly high levels on the subscales - Self-blame, Rumination, Catastrophizing, Blaming others and low scores on the subscales- Acceptance, Positive refocusing, Refocusing on planning Positive Revaluation, Putting into perspective.

- Impact of Events Scale-Revised (IES-R, Zatzick et al., 1997; Briere, 2004): in all three categories of PTSD-specific symptoms (re-experiencing the traumatic event, avoidance and hypervigilance) obtained high scores.

- Life Events Checklist for DSM-5- reported and listed events regarding exposure to numerous potentially traumatic events throughout life.

-Posttraumatic stress disorder assessment questionnaire – civilian version (PCL-C): high score suggesting a PTSD diagnosis.

No symptoms specific to disorders with psychotic elements are present.

When the client is diagnosed with PTSD, a careful assessment of the trauma history is needed, and careful psychodynamic assessment of both the meanings attributed by the person to the traumatic event and their specific psychological vulnerabilities is necessary to analyze environmental triggers (Mate, 2022).

Psychiatrist Naomi Breslau, in a study carried out by in 1991, highlighted that the risk of developing a post-traumatic syndrome could be associated with early separation from one or both parents, with a neurotic character, with a family history of anxiety or with pre-existing depression. The author concluded that a personal predisposition to PTSD is also necessary for the expression and manifestation of symptoms. Old traumas can be reawakened by current circumstances.

Results and discussion

Case description

My client, a 20-year-old man, student, requests psychological support due to an event that affected his life: 2 months ago he suffered a road accident (pedestrian hit by a car, resulting in loss of consciousness and altered general condition, Glasgow Coma Scale =8).

After 5 days of coma, he came back surprising the medical staff. Only for one day his ability to communicate and his language were affected and he experienced a slight aphasia. After a week he was discharged and continued with the medical checks, he went to the ENT because he was left with tinnitus, to the orthopedist because he had 2 more operations to do (hematoma).

The following aspects were revealed by the anamnesis:

After he was discharged, he stayed at home for several days, being too scared to leave the house. This situation lasted for more days. During this time, for the statements to the police, he was asked to recount the event several times. Each account was accompanied by intense physiological arousal and heightened feelings of fear. He doesn't feel able to go to college anymore, feels pressured to resume his normal duties and thinks he won't pass his exams in session.

He had nightmares several times a week, accompanied by excessive sweating and body movements. He was bothered by media reports that evoked road accidents, as well as idiosyncrasy stimuli (eg. white cars, which reminded him of the car that had crashed) (Dumitrache, 2020).

He avoided talking about the incident, tried to block out his thoughts, and made several changes in his lifestyle to avoid elements that might remind him of the accident.

He noticed that his mother and girlfriend complained that he is withdrawn and cold, that he no longer shows affection towards them.

The sleep became very irregular, dropping from an average of eight hours a night before the accident to three to four hours. He claimed to have difficulty concentrating, beeing unable to read or learn, and complained of problems with memory and decision-making.

He stated that he is hypervigilant when he is away from home, (situation which he avoids at all costs, he only comes out for medical checks) accompanied by an amplification of avoidance and emotional anesthesia.

His mental dispositions ranged from calm to dysthymic, often on the verge of tears. He did not understand his condition well and was unable to understand why he did not recover from the accident, interpreting this fact as evidence of weakness. He had a pessimistic attitude towards the future and stated that he felt guilty about the way he behaved with his family.

The client is characterized by emotional instability, anxiety, low affective tone, moderate depressive tendency, exhaustion, behavioral rigidity.

He lives intensely his emotions and manifests them quite visibly, experiencing the risk of not being able to control them in situations where this self-control is required.

Hypervigilance, the persistent state of physiological activation is often recalled by my client during the car ride with mom, including palpitations, tremors, sweating, dizziness, difficult breathing, rapid heartbeat.

He has a driver's license, but at the moment he cannot drive the car (hematoma on his leg, but also strong physiological reactions when he gets into the car), he says that he is nervous and very alert, he constantly feels fear or insecurity.

Nocturnal and diurnal psychomotor agitation. Daily functioning is sometimes disrupted as a result of thoughts about the accident and how this event has made it difficult for him to succeed in daily goals/activities. The client is impulsive and nervous and sometimes requires assistance with normal daily activities

He states that the traumatic event-the accident is re-experienced repeatedly in the form of:

- repetitive images, painful memories, thoughts, perceptions related to the road accident, which pass through his mind with all their negative emotional charge;

- constant flashbacks (both day and night through nightmare dreams and intrusive thoughts) related to the accident - car headlights, a bright light.

- specific anxiety reactions when coming into contact with stimuli similar to the traumatic event (cars, pedestrian crossings, screeching wheels), as well as through a series of physiological reactions (palpitations, sweating, feeling of a lump in the neck, tremors, etc.) when being in contact with these environmental stimuli.

My client certainly meets the criteria for a PTSD diagnosis: the presence of a traumatic experience, multiple trauma reexperiencing symptoms, extensive avoidance, emotional paralysis, and persistent hyperarousal.

Although he also presents symptoms of depression and anxiety, these are secondary to PTSD and do not imply a separate diagnosis.

Despite the absence of a psychiatric history or pre-traumatic problems, there is a previous tendency towards anxiety (both about himself and his parents/grandparents), accompanied by a stress reaction characterized by avoidance and denial. Although these strategies worked well in the past, they inhibited the assimilation of experiences and personal development. Traumatic memories remain unchanged and continue to invade consciousness, often causing distress (Mate, 2021; Silistraru et al, 2021).

In general, at the present time, the treatment involves a combined plan with drug intervention and psychotherapy (my client was also consulted by a psychiatrist and given drug treatment).

I dedicated the first part of the sessions to the initial evaluation of the case and worked with the therapeutic alliance. Also, in the first part of the therapy, the focus was on learning and adapting some strategies to deal with the present conditions.

The client was assisted to connect with what he was feeling. The presented problems and PTSD-specific symptoms were assessed, the psycho-education and psychological interventions aimed at developing a realistic view of the symptoms (Brousse & Peronn, 2019). I compiled a list of short- and long-term goals of the intervention.

In the second part of the therapeutic approach, we continued with the client's internal map, methods and techniques were applied that focused the client on his inner life.

We evaluated automatic thoughts, assumptions and cognitive schemas related to the trauma, but also the patient's coping schemas and the need for possible techniques to develop these skills. The client learned how

to identify his negative automatic thoughts and how to formulate rational responses.

I have identified trauma-related memories, stimuli, or situations that continue to be avoided or induce anxiety.

To decrease the anxiety and anchor my client in the present I usually use grounding techniques (targeting the five senses - sound, touch, smell, taste and sight - to immediately connect with the present moment).

With the help of grounding exercises, which use mental distractions, the client was helped to divert his thoughts from the feelings that torment him and bring him back to the present.

This is commonly used with anyone who has experienced trauma, it can be very helpful for those who experience dissociation during their flashbacks and forget where they are in the present. Finally, practicing proper breathing and controlling muscle tension through relaxation techniques can also be helpful in managing anxiety symptoms in PTSD, especially when trying to deal with their traumatic memories.

Many people who experience PTSD imagery and flashbacks report having strong physiological symptoms when re-experiencing their traumatic event, but by "grounding" and learning how to manage anxiety, the effects can be reduced and become less painful.

Systematic desensitization: The client was repeatedly exposed to brief imaginal presentations of stimuli associated with the trauma while also performing relaxation exercises. He was taught to manage anxiety symptoms through techniques such as muscle relaxation, breathing, guided mental dialogue and stopping dysfunctional thoughts.

Exposure has three major targets: memories related to the trauma, internal and external stimuli that trigger anxiety and the feeling of reliving the event, . The best results are obtained if the exposure is made for all three types of lenses.

The exposure (imaginary exposure to the memory of the trauma) took place in a safe space, when the client was prepared, he told the account of the traumatic event. The client is asked to relax into a comfortable position with their eyes closed and begin to recount the traumatic event by trying to visualize it in their mind.

The exposure was done in several stages, sessions, gradually, then resumed and adding more details. Great attention was paid to the details of sounds, images, smells, emotions and internal physiological sensations so that the client activates the memory as fully as possible and so that all significant details are incorporated into the narrative. After each exposure,

the client reports the level of distress he feels on a scale from 0 to 10 (I use a sheet for imaginary exposure where I write the progress).

As the client progresses, he will have fewer and fewer reactions and the level of anxiety is reduced. But if problems arise, what helps us in therapy is to focus on the "hot spots" in the client's story, those points that trigger the strongest emotions, and then the client is guided to talk about that part of the traumatic event.

The exposure is ended when there is some reduction in the level of anxiety. After the first exposures he is instructed to continue including his imaginary exposure at home, daily for at least 30 minutes.

The in vivo exposure, in reality, was carried out by the client together with a reference person, his girlfriend.

It was more difficult to recall the chronology of events, the client remembers all the steps until he set foot on the pedestrian crossing and then all he remembers are the headlights of the car, a bright light, even if the accident happened during the day and screeching of wheels (Rothschild, 2013).

Towards the end of the therapy I practiced facing my own fears. The best way to overcome PTSD is to practice fear-inducing situations (created a hierarchy, imagined himself in those situations, continued visual exposure to "hot spots", looked at photos that reminded him of accident, read the article in the press where the accident was reported, went and revisited the place where the accident happened).

After they were practiced and learned in therapy, as homework, the client had weekly to start:

-to monitor their trauma-related triggers during the week

- to write down avoided situations and safety behaviors

- to identify/note their automatic negative thoughts and rational responses

- practice relaxation through breathing, relaxation/mindfulness techniques

- to practice the grounding exercises learned in the office whenever he feels anxious

- exposure in the imaginary, in vivo

- engaging in previously avoided activities

In the last few sessions we have focused on relapse prevention, we recap all the techniques that seemed to be more effective and that the client was able to resonate with and work with better, we discuss the possibility that certain symptoms may return at certain stressful times in life.

Completion of the intervention must meet four specific criteria: symptoms have resolved sufficiently so that the client no longer meets the criteria for a diagnosis of PTSD, the client can discuss the trauma without being as emotionally disturbed, avoidance no longer interferes with the patient's daily functioning, and the relevant cognitive distortions have been modified.

At the moment we are in the process of catamnesis (at 3 months, 6 months and 1 year), in accordance with the principle of "remaining the doors open". This way the therapeutic addiction is also prevented and integrated by the beneficiary, through self-testing, extended awareness and responsibility, the effects of one's own self-healing/transformation work.

Given all the key words (light, beacon, loneliness, cold) that he repeated and the core themes I tried to look further into the past and hear his story as well.

Important life events that came to "light" following the therapeutic process were related to "losses" (Bolos et al., 2012). His childhood was marked by traumatic events (parental separation at the age of 1 and father's infidelity, father's death, conflicts and history of domestic violence, expressed mainly on an emotional level, his "kidnapping" by his paternal grandparents at the age of 4, the death of his grandfather, possibly suicide, at the age of 7, the death of his maternal grandmother 6 months before the accident, the one who raised him after separation of parents, history of parentification - practically he was invited as an adult to provide emotional support especially to the mother).

He was an only child and he thinks he had a normal childhood, although he says he was shy and "a bit lonely" at school. He described his mother as a nervous woman who tended to avoid social contacts. He described his family in the following terms: "there was no room for empty words - when things didn't go well, you didn't complain or discuss it, you moved on". It turns out that his usual way of dealing with stress is based on avoidance and denial.

It was very interesting and important the way the client perceived the characters in his own genogram, the connections between them and the interpretation of life events, even the gaps he had in the representation of the genogram said a lot about what was "deleted" from the family history (many childhood information), including now, fails to recall information about the accident (Onset PTSD is caused by trauma, as its name suggests. The exact function of PTSD is thought to be initially protective; the mind protects itself from the severity trauma to remove the shock Over time, however, if the memories are not safely and effectively dealt with and sorted

out, they can become a proverbial thorn in the mind and will continue to cause mental and even physical symptoms until the trauma is thoroughly treated).

These symptoms are the result of changes occurring in the regions of the brain that deal with emotions, memory and reasoning. Areas affected may include the amygdala, hippocampus and prefrontal cortex).

My client was raised only by his mother and grandmother, the father was absent from his life, the parents were not married. When the client was 1 year old, the parents separated, and shortly after he died in a car accident (alcohol consumption) when my client was 2 years old.

We can also talk about behavioral genetics, he lived in a family with an anxious-depressive model. Thus he took over the anxious-depressive way of thinking and acting and found the repressed emotions during childhood, but also the unlived emotions from the paternal vein, emotions that were subject to the prohibitions, principles and conservatism of the family . In the client's history were also events with negative meaning, repetitions related to unfortunate experiences/events.

The paternal role was taken over by the mother, with whom she had a cold and conflicting relationship. Authority and responsibility are more associated with women.

The client presented a poor differentiation of the self from the family of origin and an avoidant type of attachment.

Loyalty to mother and grandmother, the existence of events in childhood indicated the emotional unavailability of parents.

The introjected family myth contains messages about blocking communication initiatives, reluctance to talk about important and personal, secret things.

The Sun, the male part of the Universe, is the symbol of the father, is the symbol of life, the source of light and illumination, the joy of living and the force to shine (a symbol that was used and found in many discussions with my client).

In starting the therapeutic intervention multiple aspects were considered: the life history of the client and his family, the collection of information related to borders, rules, rituals and family loyalties, received in the familiar environment, significant life events, defense and survival strategies.

Thus, we used expressive-creative and psycho-corporal methods and techniques in the manner of experiential psychotherapy: creative meditation, role-playing, genogram, exercises for expressing intense emotions, metaphorical scenarios, stories and therapeutic cards, psycho-corporal

techniques, art therapy. (Family Drawing through symbols, Problem Drawing, I used the fantasy "Fight of the Ship and the Storm", The Wall Metaphor, Visual Imagery-Running Water, Dialogue of the Parts, The Empty Chair, I Am...etc.).

Conclusions

PTSD is not a linear disorder - my client did not immediately show PTSD symptoms. This is one of reasons why the disorder can be insidious: weeks, months, and more can pass before symptoms appear, making self-detection difficult or confusing. My client felt he was starting to "lose his mind" when the nightmares became persistent and the flashbacks became more frequent about 1 month after the accident.

Initially, therapy focused on stabilizing the affected person so that they are able to express their feelings in a positive way, improve their connections with others, reduce mistrust and negative visions, and eliminate unpleasant memories and anxiety.

After experiencing traumatic events, memories of the event may be associated with what the person saw, smelled, heard, or felt during those traumatic moments. Later, similar sights, sounds, smells, or emotions can activate traumatic memories and overwhelming emotions.

Another reason why these emotions persist is because traumatized people need to explain what happened, to make sense of it. Coping with traumatic events often causes the person to question their previous beliefs.For example, the person begins to doubt their belief that the world is a safe place or that nothing bad will happen to them. To find an acceptable meaning, these people need to think about what happened to them and the implications of the event.

But as they think about the event, they will also recall what happened to them and relive the related affective states. Consequently, these people will try to stop thinking about the event. As a result, instead of being able to understand what happened to them and reach a stable emotional state, these people continue to oscillate between recalling the event and trying to forget it.

Bessel van der Kolk, director of the Trauma Center at the Justice Resource Institute and professor of psychiatry at Boston University, says PTSD develops when a traumatic experience becomes stuck in the body (Van der Kolk, 2018).

The physical experience of trauma creates a disconnection between the traumatized person and their body, basically a split between the person and the self. He refers to this as a lack of control over one's own body,

stating, "Trauma is not a story about the past, it's about how the past continues to live in your body; that is the main problem".

Sigmund Freud also mentioned that psychic trauma, or the memory of it, acts as a foreign (alien) body which, once penetrating inside, remains a functional factor for a long time.

Do you know the story of the Knight? The King was pleased with his Knight because he was the best, the bravest, so he gave him a suit of armor made of gold and precious stones.

The knight wore it proudly every time he met the king and when he went to battle. But slowly, slowly he forgot to take it off, he always wore it, at home, in his sleep, everywhere even though it was getting heavier and heavier!....a metaphorical story that very succinctly explained Post Traumatic Stress Disorder.

References

Bisson, J. I., Ehlers, A., Matthews, R., Pilling, S., Richards, D., & Turner, S. (2007). Psychological treatments for chronic post-traumatic stress disorder: Systematic review and meta-analysis. *The British journal of psychiatry*, *190*(2), 97-104. doi:10.1192/bjp.bp.106.021402

Bolos, A., Ciubara, A., & Chirita, R. (2012). Moral and ethical aspects of the relationship between depression and suicide. *Revista Romana de Bioetica, 10*(3): 71-79.

Bovin, M. J., Marx, B. P., Weathers, F. W., Gallagher, M. W., Rodriguez, P., Schnurr, P. P., & Keane, T. M. (2016). Psychometric properties of the PTSD checklist for diagnostic and statistical manual of mental disorders–fifth edition (PCL-5) in veterans. *Psychological assessment*, *28*(11), 1379 https://doi.org/10.1037/pas0000254

Brady, K. T., Killeen, T. K., Brewerton, T., & Lucerini, S. (2000). Comorbidity of psychiatric disorders and posttraumatic stress disorder. *Journal of clinical psychiatry*, *61*, 22-32. https://www.psychiatrist.com/read-pdf/3403/

Briere, J. (2004). *Psychological assessment of adult posttraumatic states: Phenomenology, diagnosis, and measurement* (2nd ed.). Washington, DC: American Psychological Association

Brousse M., & Peronn V. (2019). *The body does not forget*. Philobia Publishing House, Bucharest.

DSM-5 (2013). Diagnostic and statistical manual of mental disorders (5th ed.). American Psychiatric Association. Washington, DC

Dumitrache, S.(Coord.) (2020). *Body, trauma, healing. Diagnosis and psychotherapeutic intervention.* SPER Publishing House, Bucharest.

Izzat, A. A. H., Anghel, L., Stefanescu, B., Kantor, C., & Ciubara, A. (2021). Prevention of psychoactive substance use. *Archiv Euromedica*, *11*(5), 59-61.DOI: 10.35630/2199-885X/2021/11/5.16

Levine, P. A. (2020). *Traumatic stress. Trauma healing.* For You Publishing House.

Levine, P. A. (2022) *In an unspoken voice: How the body releases trauma and restores goodness.* Pagina de Psihologie, Bucharest.

Luca, L., Ciubara, A. B., Antohe, M. E., Peterson, I., & Ciubara, A. (2022). Social media addiction in adolescents and young adults-psychoeducational aspects. *Archiv Euromedica,12*, Special Issue, DOI 10.35630/2022/12/psy.ro.16

Mate G. (2021). *When the body says no. The hidden cost of stress.* Curtea Veche Publishing, Bucharest.

Mate G. (2022). *The myth of normality. Trauma, illness and healing in a toxic culture.* Herald Publishing House, Bucharest.

Rothschild B. (2013). *The body remembers. Psychophysiology and trauma therapy*. Herald Publishing House.

Silistraru, I., Ciureanu, A. I., Ciubara, A., & Olariu, O. (2021). Prevalence of burnout in medical students in Romania during COVID-19 pandemic restrictions (preliminary data). *Archiv Euromedica*, *11*(5), 12-15. http://journal-archiveuromedica.eu/archiv-euromedica-05-2021/archiv_euromedica_05_2021_001_075_WEB_03.pdf

Van der Kolk, B.(2018). *The body never forgets.* Adevăr Divin, Brașov.

Zatzick, D. F., Marmar, C. R., Weiss, D. S., Browner, W. S., Metzler, T. J., Golding, J. M., ... & Wells, K. B. (1997). Posttraumatic stress disorder and functioning and quality of life outcomes in a nationally representative sample of male Vietnam veterans. *American Journal of Psychiatry*, *154*(12), 1690-1695. https://doi.org/10.1176/ajp.154.12.1690